FEB 13 1985
FEB 19 1985

Y 4. Ap 6/p: S. hrg. 98-1302

S. Hrg. 98-1302

Senate Hearing

Before the Committee on Appropriations

COMPLETED
91

ORIGINAL

Community Health Care in Mississippi

Fiscal Year 1985

98th CONGRESS, SECOND SESSION

SPECIAL HEARING

BEST COPY AVAILABLE

S. HRG. 98-1302

COMMUNITY HEALTH CARE IN MISSISSIPPI

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

SPECIAL HEARING

Printed for the use of the Committee on Appropriations

U.S. GOVERNMENT PRINTING OFFICE

40-415 O WASHINGTON : 1985

BEST COPY AVAILABLE

COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEE ON DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

LOWELL P. WEICKER, JR., Connecticut, *Chairman*

MARK O. HATFIELD, Oregon	WILLIAM PROXMIRE, Wisconsin
TED STEVENS, Alaska	ROBERT C. BYRD, West Virginia
MARK ANDREWS, North Dakota	ERNEST F. HOLLINGS, South Carolina
WARREN RUDMAN, New Hampshire	THOMAS F. EAGLETON, Missouri
ARLEN SPECTER, Pennsylvania	LAWTON CHILES, Florida
JAMES A. McCLURE, Idaho	QUENTIN N. BURDICK, North Dakota
PETE V. DOMENICI, New Mexico	DANIEL K. INOUYE, Hawaii

Majority Professional Staff

CLAUDIA INGRAM, GAR KAGANOWICH, RIKI POSTER SHEEHAN, CAROL ORTEGA, JAMES SOURWINE, AND STEVEN BONGARD

Minority Professional Staff

TOM VAN DER VOORT AND MARION R. MAYER

Administrative Support

TERRY L. MUILENBURG, NANCY C. ANDERSON, PATRICIA F. FALSEY, AND BARBARA L. RHODEN

BEST COPY AVAILABLE

CONTENTS

NONDEPARTMENTAL WITNESSES

STATE AGENCIES PANEL

	Page
Phil Laird, executive director, Mississippi Health Systems Agency	1
Statement of	3
Earl Hendricks, director of project review, Mississippi Health Systems Agency	1
Statement of	6
Robert Pugh, Mississippi Health Care Commission	1
Dr. Earl Fox, chief, bureau of personal health services, Mississippi State Department of Health	1
Prepared statement	9
Statement of	7

COMMUNITY HEALTH CENTER PANEL

Ron Crawford, executive director, Mississippi Primary Health Care Association	18
Statement of	22
Clyde L. Mock, president, Mississippi Primary Health Care Associaton; project director, Madison-Yazoo-Leake Family Health Center in Canton	18
Prepared statement	19
Statement of	20
Dr. Richard J. Enochs, director, Mound Bayou Community Health Center	18
Statement of	24

COMMUNITY HEALTH CENTER PANEL

Harold Spees, director, New Hebron Rural Health Initiative	36
Statement of	37
Ms. Kaye Ray, director, Southeast Mississippi Rural Health Initiative	36
Statement of	36
Dr. Aaron Shirley, director, Jackson-Hinds Comprehensive Health Center	36
Statement of	40

HOME HEALTH ASSOCIATIONS AND AGENCIES PANEL

Elaine Burchfield, president, Mississippi Home Health Association	48
Statement of	49
Donald W. Baxter, president, South Mississippi Home Health and Rehabilitation Agency	48
Letter from	59
Statement of	49
Marilyn Williams, Mississippi Hospital Association	48
Prepared statement	54
Statement of	51

BEST COPY AVAILABLE

COMMUNITY HEALTH CARE IN MISSISSIPPI

MONDAY, MAY 21, 1984

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10 a.m., at the Colisieum Ramada Inn, 400 Greymont Avenue, Jackson, MS, Hon. Thad Cochran presiding.

Present: Senators Cochran and Weicker.

NONDEPARTMENTAL WITNESSES

STATE AGENCIES PANEL

STATEMENTS OF:

PHIL LAIRD, EXECUTIVE DIRECTOR, MISSISSIPPI HEALTH SYSTEMS AGENCY

EARL HENDRICKS, DIRECTOR OF PROJECT REVIEW, MISSISSIPPI HEALTH SYSTEMS AGENCY

ROBERT PUGH, MISSISSIPPI HEALTH CARE COMMISSION

DR. EARL FOX, CHIEF, BUREAU OF PERSONAL HEALTH SERVICES, MISSISSIPPI STATE DEPARTMENT OF HEALTH

OPENING STATEMENT

Senator COCHRAN. The hearing will please come to order.

Let me announce at the outset that this hearing has been authorized by the Senate Appropriations Committee and specifically the Subcommittee on Health and Human Services chaired by Senator Lowell Weicker of Connecticut.

Senator Weicker is on his way to Jackson right now and his flight will be in in a little while. We are expecting him to be here. I'm going to go on and start the hearing in his absence and then he will assume the chair as soon as he gets here.

I want to express my appreciation to Senator Weicker and members of his staff for helping get this hearing scheduled and authorized and making arrangements and doing the planning for the conduct of the hearing. We're specifically interested in looking at programs that are designed to extend health care services to the rural poor, the elderly, those who have a difficult time gaining access to traditional health care re-

BEST COPY AVAILABLE

sources. Here in Mississippi, we have a lot of problems in that area because we have a lot of poor people, people who do not live in urban areas, where transportation is difficult and expensive. The home health service agencies are important to these people as well as the health centers both of which are supported by the Federal Government. Funds for these programs are made available on the recommendation of this subcommittee. I serve on the Senate Appropriations Committee and we are interested in determining what the appropriate level of funding for these activities should be. There are authorization questions that are before the Congress now, legislation to reauthorize these programs. Senator Weicker serves on the authorizing committee as well. So I'm delighted that he has acceded to my request and agreed to come to Mississippi today for the purpose of looking at the special problems that we have here in these areas. They are very important. In some parts of the State they are acute.

We have representatives of the home health agencies and the community health centers here today, and I want to express my appreciation to all of you for coming to be with us. Some have come long distances.

We're going to divide up the presentation of information to the committee into panels of witnesses. The first panel will include State agencies who have a very important role to play in this effort. Then we will hear from a panel of witnesses who operate community health centers. And our last panel of witnesses will be representatives of home health agencies.

I think this will be a very important hearing. We will take the information which we get here today back to Washington with us and I think it will be very helpful in determining the kinds of changes that might need to be made in authorizing legislation which is before the Senate and in determining the levels of funding that might be appropriate for these activities.

So, without any further statements by me, I'm going to invite the first panel to come forward to the witness area. This will include Mr. Phil Laird, who is executive director of the Mississippi Health Systems Agency here in Jackson; Mr. Earl Hendricks; Mr. Robert Pugh of the Mississippi Health Care Commission; and Dr. Earl Fox of the State Board of Health.

Let me also introduce to you others whom I notice who are here but who will not testify. I notice my father is here and Charlie Johnson, both of whom are very active in the retired teachers association, American Association of Retired Persons. They have a role to play this year in presenting to State legislatures and Congress, too, concerns of older citizens about hospital costs and hospital cost containment. These are issues that are related to those that we will be discussing this morning.

Well, we have three witnesses here. Who are we missing? Why don't you just go ahead and introduce yourself and each of you can tell us who you are so we'll have that for the record.

BEST COPY AVAILABLE

Mr. HENDRICKS. First of all, I'd like to say good morning to you, Senator Cochran, and also the staff—Senator Weicker's staff and your staff. My name is Earl Hendricks. I'm the director of project review for the Mississippi Health Systems Agency.

Dr. FOX. Senator, I'm Earl Fox, chief of bureau of personal health services for the Mississippi State Department of Health.

Mr. LAIRD. Good morning, Senator. I'm Phil Laird, executive director of the Mississippi Health Systems Agency.

Senator COCHRAN. Thank you, and welcome.

Let me ask you, Mr. Laird, to go ahead and lead off. We have statements that have been prepared and they will be included in full in the record. We would encourage you to make summary comments or abbreviated comments from those written statements as you care to and permit us an opportunity for questions or discussions of points that you raise. So you may proceed.

STATEMENT OF PHILIP W. LAIRD

Mr. LAIRD. I am accompanied by Mr. Earl U. Hendricks, director, division of project review and monitoring, who will also testify. Today, I would like to address the necessity of continued local planning involvement in the access of all Mississippians—particularly rural Mississippians—to quality care at a reasonable cost.

We appreciate this opportunity given us by this subcommittee to provide our views on health planning, community health centers, home health care, and the National Health Service Corps.

The Mississippi Health Systems Agency has since its inception in 1976—been primarily interested in the rural primary care needs of the State. We established a primary care assessment team which surveyed rural areas of Mississippi to determine the actual unmet need that existed; located and generated funds for the development of rural health initiative clinics throughout the State; provided technical and grantsman assistance to communities; assisted communities to become private, nonprofit, or other legal entities for the purpose of receiving grants and other assistance; recruited and found sources of funds to retrain registered nurses to become nurse practitioners to operate these clinics under the supervision of a local physician; and under PUFF review, approved and championed the funding of each. It was our intent—to the extent possible—to develop a regional complex of rural health initiative clinics under a single administrative unit, such as the one that was located in a nine-county area of east central Mississippi. Under PUFF review, this was possible. But with the reduction of Federal support, the sole authority for PUFF review was returned to the regional office of the Department of Health and Human Services with the HSA's involvement reduced to review and comment on newly funded competing applications. As a result, with the supervision of these clinics coming from Atlanta, the services being provided by these clinics are often fragmented and sometimes duplicated.

BEST COPY AVAILABLE

With this in mind, I would strongly encourage Senator Weicker to return PUFF review to the HSA's or other appropriate local health planning agencies in the Health Planning and Resource Allocation Act of 1984.

NATIONAL HEALTH SERVICE CORPS

America is one of the countries most heavily populated by physicians. There still exist many areas of the States that are medically underserved. The National Health Service Corps has assisted greatly in filling this gap. The corps' goal for next year is to place 53 additional physicians within five States in areas of critical need.

Since its inception, the Mississippi Health Systems Agency has taken the lead role in designating certain areas of the State as health manpower scarcity areas, for the purpose of recruiting health professionals into these areas through the National Health Service Corps. In fact, this is the major function of our division of plan implementation. Until recently, this agency housed the National Health Service Corps office and staff. Some problems that we have encountered are as follows:

Veto power by local physicians.

No real accurate count of physicians. No accurate method of determining FTE. Full-time may mean anything from 30 to 70 hours per week. No discounting FTE for age or physician condition. No consideration for the use of ancillary personnel in physicians offices.

Most NHSC physicians do not have and have not sought hospital privileges.

Opportunities' lists are developed more than 12 months in advance and are not responsive to community change.

MSHA not designed to operate quickly to satisfy community emergencies.

LOCAL HEALTH PLANNING

We strongly appreciate and support Senator Weicker in his efforts to achieve health planning reauthorization. We also agree with the importance of planning in controlling the rapidly accelerating health care costs. However, there are several items of the Health Planning and Resource Development Act of 1984 that disturb us.

First: The Mississippi Health Systems Agency—as have other HSA's throughout the Nation—has been successful in assisting rural health efforts, including resource development, expanding rural primary care, long-term care, maintaining access to needed rural hospital services and providing a forum for a voice for rural community concerns. Yet, there is no guarantee that the States will continue local health planning programs, should they apply for and receive the supplemental health planning and resource allocation grants authorized in the proposed act. We would prefer that existing local health planning agencies be retained, strengthened, and redirected toward health care cost containment activities.

BEST COPY AVAILABLE

Second: We applaud Senator Weicker for including in his bill—S. 2482—a stipulation that two-thirds of members of the State advisory board be major purchasers of health care, but we are concerned that the bill requires the advisory board to meet only once each year. We are firmly convinced that the involvement of the private sector of business and industry will lead to the establishment of many procompetition models within the Nation. However, we feel that this same structure will be vastly more effective on the local, rather than the State, level.

Third: We find the funding level proposed in the act sorely lacking and would strongly recommend that at a minimum both State and local health planning agencies be returned to their 1981 funding levels: State agencies, $30 million; local agencies, $50 million; and centers for health planning, $2 million.

Fourth: In a rural State like Mississippi, it would be extremely difficult to obtain matching funds or non-Federal contributions due to the lack of available corporations and corporate donors and the severe cuts in State and local government funding. In fact, there is much discussion as to whether a special session of the State legislature must be called this year for the purpose of raising taxes solely to get through this year. I seriously doubt that the State would be willing or able to provide matching funds to support a local health planning program.

Fifth: We agree that the CON Program could become exceedingly complicated and cumbersome, and the whole process should take no more than 90 days to reach a final State agency decision. In this State, the State agency and the HSA has been working together for the past 3 years to streamline the process which now rarely requires more than 90 days to complete. The provision in the act that states that if a decision by the State agency is not reached in 120 days that the CON proposal is to be considered approved defies the cost containment intent of the act. Penalties should be levied against the State agency for a slow decision and not the taxpayers and consumers of the services to be provided through the life of the project.

Finally: Under the current Federal funding cutback efforts, rural health services are at a distinct disadvantage, as are local health planning efforts to protect these precious resources.

HOME HEALTH CARE

Home health care has demonstrated that it is an effective cost containment measure over institutional care. There are several procompetition bills being developed in both Houses of Congress. We recommend that home health care be included as an integral part of the final procompetition bill as a part of the continuity of care package.

In conclusion, local health planning which builds upon and not replaces the present health systems agency systems, is an absolute must if we are to contain and control the rapidly rising costs of health care during the next few years. Local health planning has demonstrated that it has the capability of cutting across bureaucratic barriers to get the job done.

BEST COPY AVAILABLE

Thank you.

Senator COCHRAN. Thank you very much, Mr. Laird. We appreciate your excellent statement.

I think before going into any questions or discussion of your statement, we'll go on and hear from the other witnesses. Since Earl Hendricks comes from the same agency, Mississippi Health Systems Agency, let's hear from you now and then we'll hear Dr. Fox.

STATEMENT OF EARL HENDRICKS

Mr. HENDRICKS. The issue of primary health care for rural and medically underserved/health manpower shortage areas demanded a comprehensive review in an effort to establish and provide a mechanism by which the public demand/need can be realized.

Since October 1976, the Mississippi Health Systems Agency, Inc. [MSHA] has continued to develop, modify, use, and manage a review structure and process, in accordance with Federal, State, and local laws. One of the agency's goals through the planning, review and monitoring, and implementation process is to assure that the development of health care resources within the health service area will fulfill and implement the objectives of the health systems plan [HSP] and the annual implementation plan [AIP]. Coupled with this goal is an attempt, through the review process, to provide accessibility and availability to primary health care, combat increasing health care costs and the unnecessary duplication and maldistribution of health care manpower, facilities, and services.

To this end, MHSA continues to play a major role in providing technical assistance to communities and counties, identifying health manpower shortage areas in the State, recruiting health manpower—most physicians and dentists—assisting in the development and review of proposals for areas in need. Presently, there are approximately 23 grant programs—community health centers and rural health clinics—or independent sites.

Since 1976, the MHSA has reviewed annually some 30 grant programs—community health centers, rural health clinics, and independent sites—as new, continuation, and expanded services' applications under the proposed uses of Federal funds [PUFF]. Presently, we are involved in a county in the southeastern portion of the State, which has a population of 12,622—74.8 percent nonwhite; 25.2 percent white—in a supervisory district with an 18-percent elderly population; poverty level in excess of 30 percent; and an estimated 5-year average infant mortality rate of 26 deaths/per 1,000 live births—nonwhite; without adequate availability and accessibility to primary health care. The HSA has honored a request for subcounty designation of this area and sent the request to DHHS in Washington, DC—Rockville, MD. In addition, we are providing technical assistance in preparing a grant application for submission to the HHS regional office in Atlanta. We are hopeful that the area is designated and grant application is completed and funded. The end result would mean the availability and accessibility of health care for 12,622 persons.

BEST COPY AVAILABLE

However, no system or process is without problems. Whereas the MHSA is totally involved in the aforementioned project, through lack of communication or miscommunication with the communities in need and reviewing funding entities of DHHS, many problems arise. Because of this communication problem, programs are not established where there is a need, or programs are reviewed, funded, and operational without MHSA having knowledge of a demand/need in a given area of the State.

Second, there still exists within the minds of some consumers and providers of health care that community health centers and rural health centers are for the poor only. Also, that they usually provide inadequate health care. It should be noted that these centers provide an entry level into the health care system through primary medical care, education, and prevention for all segments of the population.

Finally, MHSA, through use of Federal funds to establish community/rural health centers, is in the best position to continue assisting to more appropriately meet the primary health care needs of individuals consistent with local circumstances.

While health programs have experienced budget cuts, along with all the other Government programs, we must not lose interest. Now, more than ever, we must push for greater flexibility at the Federal level and greater responsiveness at the local level.

In summary, I once again would like to thank you for allowing me to testify before this subcommittee. I trust that you will see the need for continued funding for community health centers, health planning on the national and local level, more specifically, for the State of Mississippi.

Senator COCHRAN. Thank you very much, Mr. Hendricks, for your presentation.

We will now hear from Dr. Earl Fox.

STATEMENT OF DR. EARL FOX

Dr. Fox. Thank you, Senator. We appreciate the opportunity to be able to testify here today, and before I give my comments, I'd just like to say how much the department appreciates your support over the past several years for the programs which I think have benefited our State so much, like WIC, maternal/child health, primary care centers. Although the majority of my comments today are targeted toward the primary care centers, I'd like to state a couple of additional comments about the National Health Service Corps and home health services.

As you know, Mississippi in October took over the administration of the National Health Service Corps contract. This was a first for Mississippi and I think, on the whole, has been very positive for us. However, the corps is graduating its largest class of physicians ever this year and Mississippi is scrambling to find places to put these physicians. I think that—I'll be glad to answer questions on this later, but we certainly need increased flexibility with placement through the corps.

BEST COPY AVAILABLE

In addition to that, the Home Health Program is administered in some areas through our agency and we provided 240,000 home health visits this past year through the department of health, and I think we're probably the single largest home health provider in the State, and I would just like to speak in support of that program and for the fact that as DRG's come into increasing implementation over the next several years, I think there is going to be an increasing need for home health services as patients are discharged earlier from hospitals. The seed grants from the Federal Government to expand home health services have been quite useful to us and I'm sure others as well.

In regard to primary care centers, the State department of health has been involved with primary care centers in a number of different ways. We administered for a short period of time the Holmes County primary care service several years ago. We've been involved in a cooperative agreement with the primary care centers through the Governor's office in trying to just increase the communication, and then I've been a part of both a task force that has met on the regional level and also a group of individuals who are trying to look at primary care standards that would hopefully improve the quality of care for primary care centers throughout the region. Although both the primary care centers and the regional office, in my opinion, have tried diligently to improve the quality of services, I think there are some inherent problems that exist and I'd like to address a few of those today.

PREPARED STATEMENT

Senator COCHRAN. Thank you very much, Dr. Fox, for your excellent statement which will be placed in the record.

[The statement follows:]

BEST COPY AVAILABLE

STATEMENT OF DR. EARL FOX

I appreciate the opportunity to share my comments with you today. The Mississippi State Department of Health has for a couple of years now been involved in a cooperative agreement with the primary care centers through monthly meetings coordinated by the Governor's Office. In addition, we administered for a period of time a primary care project in Holmes County. Other than this local involvement, I have attended several Regional Task Force meetings in Atlanta with primary care project personnel and I am a member also of a primary task force charged with the responsibility of looking at various clinical care standards throughout the region. Although both the primary care centers and the regional office have tried diligently to provide appropriate services, I believe some inherent problems exist.

First, the regional office has neither the manpower time, travel dollars or other resources necessary to provide the intense ongoing technical assistance and coordination needed by the centers. Quality care assurance has been variable and difficult to assess. Although some standards for evaluation do exist and others are being developed, centers in the past have often been judged by criteria developed "on foot" and recommendations frequently hinged on the whims of the reviewer or the reviewing team. Although some standards such as those reported under a document called the BCRR are available, these are inadequate and at best may not give an accurate reflection of center activity, either in quality or quantity of services provided. Restricted travel dollars at the regional office level have made onsite evaluation and supervision infrequent and inadequate. Regional office supervision of primary care centers is complicated, not only by lack of resources and the number of centers, but also by the distance involved.

Primary care centers in Mississippi and probably most other states as well flounder because of a lack of technical assistance and coordination. It appears that what is needed is some type of state level presence. This would serve several functions and could be done in a variety of ways.

BEST COPY AVAILABLE

First, let's look at the utility of this approach. The smaller primary care centers in this state, the majority of the centers I might add, lack expertise in the evaluation of managerial and clinical services. Centers are expected to meet community health needs, but often are not shown how to do a community needs assessment. They are expected to be efficient and utilize clinic personnel to their maximum, but may not be shown how to do such things as evaluate clinic appointment systems, clinic patient flow and coordinate provider time in order to maximize patient loads. Center staff are expected to handle appropriately medical problems and various crises, but often do not have the technical assistance to do so in a timely fashion. The advantage of having a state level resource to the centers could be seen by looking at an example in the public health system in Mississippi. The Mississippi State Department of Health operates 100 full-time clinic sites and 80 part-time clinic sites with 500 public health nurses, 50 full-time physicians, 50 nurse practitioners and 290 part-time physicians. Protocols have been developed and made available in local clinics for such areas as maternity and pediatric care and immunization practices, to mention a few. Common records, follow-up and tracking systems are also used. A common fee system with a sliding fee scale is used statewide. Internists, pediatricians, obstetricians and others are available for consultation to local clinics and are actively involved in developing and updating clinic protocols of care. An Operations/Management Analysis Office has developed mechanisms to evaluate efficiency of clinic personnel. These and many other areas of technical assistance are available to <u>any</u> health department regardless of how large or small. In contrast although some larger primary care or community health centers, such as the Jackson-Hinds Comprehensive Health Center, may have these capabilities in-house, most centers in this state go sorely lacking. Although I believe most primary care centers are doing the best job they can, their "toiling in the vineyards" could in most instances be made easier and more productive by the type of assistance I have outlined above.

The above mentioned comments are not designed to advocate that primary care centers come under the supervision of public health departments. With the current restrictions on availability of administrative monies for such a

BEST COPY AVAILABLE

structure, and with the existing requirements for local governing boards, this would be difficult at best to implement. Public health departments if given this task would not only require dollars to add administrative and technical support, but would need the ability to establish common policies and standards that would be almost impossible with the current requirement for local boards. These two areas would need to be adequately addressed before public health departments could be considered as a vehicle for such tasks.

Another option would be one similar to that now used by the National Health Service Corps. Many states have recently accepted contracts with the National Health Service Corps. One such contract has been in place in Mississippi since October, 1983. Under such a contract, an assignee could be placed with a state agency such as the Governor's Office or health department. This contract could also provide other staff, travel and support dollars in order to coordinate between regional, state and local levels. It could facilitate communication, provide technical assistance and monitoring of local centers and make available the managerial and other resources of the state agency.

In summary, there is a problem. Despite the hard work and the best intentions of both regional and local staff, it is not salvageable with the current structure and resources. Various state entities such as the Governor's Office, State Department of Health and others stand ready to help if asked. The pertinent issue is not one of control, but of coordination, assistance and ultimately the quality of care delivered at the local level. We feel that due in large part to the Governor's Task Force on Primary Care, trust and cooperation between the various groups has in recent months skyrocketed and that hopefully as a result the quality and coordination of services in Mississippi has improved. We stand ready to assist in whatever way we can in addressing both the needs of the centers and the citizens of this State.

Thank you very much.

BEST COPY AVAILABLE

Senator COCHRAN. Before we get into a discussion of your presentation, let me introduce some administration officials who are here today at the request of the committee to help answer questions that might arise or provide information that may be needed during the course of the hearing. As I introduce you, will you please stand.

Mr. George Waterhouse, who is Deputy Branch Chief for Primary Care Division of Health Services for the Public Health Service, Atlanta.

Mr. William Crockett, Division of Program Operations, Medicare.

Mr. Hugh Miller, Survey and Certification, Program Operation Specialist.

We appreiate your being here to assist in our hearing.

Let me also introduce staff members who are here today: Jackie Knox, who is a member of my staff in Washington, a legislative assistant who specializes in health care areas and other areas as well, and Claudia Ingram of the committee staff who has been primarily working with Senator Weicker as chairman of the subcommittee, setting up this hearing and assisting in the conduct of the committee's business in Washington. They are both excellent staff members who we rely on quite a bit. Many of you here have had an opportunity to contact us in Washington for information or assistance over a period of years, and I know many of you have gotten to know Jackie Knox quite well in doing that. And I appreciate her being here today assisting with the hearing.

In connection with the development of a program for placement of physicians, the Public Health Service has, as you say, made available a large number of physicians and there is more flexibility needed in that program. Could you make a suggestion to us? Do we need to make legislative changes or is this something that can be handled by a different approach, by the administrators? What would your suggestion be about getting at that greater degree of flexibility?

Dr. FOX. Well, I think that is an awareness right now, Senator, that there is a need for this. When we have 20 something sites and 50 something physicians that have come into the State, it's obvious we've got to do something. But I think that one of the things that we're looking at is the placement of, say, physicians in areas that maybe don't qualify, if you look at the overall medical manpower, but areas, say, perhaps where the physicians are not actively involved in taking medicaid, where even though there may be physicians, there may not be access. And an example of this would be, say, Charity Hospital, right now where there's a need for additional physician manpower in an area such as Meridian where the local physicians over there may not be involved in seeing patients with Government third-party payments, but where there's still a problem with health care access. If you look at Meridian and Lauderdale County, it doesn't qualify on the basis of a medically underserved area. But if you look at it on the basis of access, it does—it should. And we are looking at trying to recommend physicians like internists, pediatricians, and obstetricians be available in those centers. The other areas like some of the counties in the State where there are a

BEST COPY AVAILABLE

number of primary care physicians that provide OB services but there's no obstetrician to provide high risk maternity care. And if you look at it again on the basis of a medically underserved area, it doesn't qualify, but there's a need.

So I think that those type things would need to be taken into account, and we've made some recommendations along that line.

The other is that I think that there's an interest now—and I would hope that this committee and subcommittee will support that—of looking at areas in smaller designations than county levels. In the past, they've looked at counties as far as trying to determine center commitments or areas, and I think there is an interest now in looking at subdesignations of counties because there may be a pocket within a county where there's a need and if you look at the whole county it wouldn't qualify. So these are some things that I would think need to be done.

Senator COCHRAN. I notice that there is a role to be played by the State agencies in certifying areas as eligible. Does your agency do that, Mr. Hendricks?

Mr. HENDRICKS. Yes, Senator; we have—as I stated earlier, if a particular request comes into our agency, we prepare the necessary data and other information that gives the number of primary care physicians in an area, the infant mortality rate, the elderly and poverty level, and that is handled through our plan implementation and coordination division. And as Dr. Fox was speaking of concentrating to local areas, this is what my example was about. It was——

Senator COCHRAN. Jones County.

Mr. HENDRICKS. Yes; Jones County as a whole is not designatable but a specific subarea or supervisory district in there, we feel is. So we put together that information, sent forth the letter to Washington or the appropriate authorities to say that we feel there is a health manpower shortage area here; we would like to have it designated. And we go a step farther, as we said, by actually assisting the people in need and putting together an application to have, hopefully, a center put there and this area funded.

Senator COCHRAN. So that application is pending now.

Mr. HENDRICKS. Right, it is.

Senator COCHRAN. Under the current procedures, would there have to be a change in the regulations or change in the legislation that would permit the designation of an area within a county if the county is not eligible?

Mr. LAIRD. No, sir; I don't see that as being a necessity at this time. One, the Board of Health has received the contract with the Department of Health and Human Services for carrying out this particular function, and they have the authority to establish the administrative rules that would take care of those particular problems. The subareas—we have designated subareas. We have subcounty areas we have designated enumeration districts, census districts in the past, particularly for dental services, where we haven't talked about this morning, but dental services is also a very strong part of the National Health Service Corps.

40-415 O - 86 - 2

BEST COPY AVAILABLE

But repeating, I do not see the need at this particular time that Dr. Fox makes, since he's responsible for that program, to take care of that particular problem. I think it could be handled quite well through the administrative proceedings of the Board of Health.

Senator COCHRAN. We're going to be hearing from others specifically with reference to the community health centers and the services provided through those centers. Do you see, Dr. Fox, any unnecessary duplication of effort or services between the State board of health and what your agency does and what is done by the community health centers? Is that something that our committee ought to look into?

Dr. FOX. Well, Senator, I can't speak for other States, but I can say in Mississippi I do not believe there's much, if any, overlap. I feel like if we serve a population—for instance, the public health departments serve a large population of maternity and child health patients, family planning. The community health centers serve those patients in some areas, but, also, I guess there has been some division of that, and we get referrals from community health centers. Community health centers, in many instances, then serve older patients, patients with other types of illnesses that we do not cover. So I don't really feel that there's a serious problem with overlap or duplication.

In regard to your question about the corps——

Senator COCHRAN. Yes.

Dr. FOX [continuing]. We can make recommendations, and we have as far as some of these subareas; however, the ultimate decision about the designation does not rest with us, and we have been frustrated in some instances where we've made recommendations for certain areas to be designated for a physician and then we would get notification from Washington that instead some other area that, in our opinion, was very low on the priority list would be designated. I can find out and will be glad to furnish your committee in writing any opinions we might feel would bear on the need for legislation or legislative changes.

Senator COCHRAN. I appreciate that, because we do have an opportunity this year to make changes. We do have legislation that's before the Senate, as you know, and we're hoping that we get that reauthorized.

Mr. Pugh has come into the hearing room. We welcome you, Robert Pugh with the Mississippi Health Care Commission.

Let me ask you this: We're constantly hearing about the fact that the law really encourages in many instances the institutionalization of persons who might have alternative care provided, such as home health care. What role does your commission play in looking into situations of this kind, helping promote home health programs?

Mr. PUGH. Senator Cochran, I apologize for being late this morning and I realize this is a very, very valuable hearing, and I appreciate the opportunity to address this panel.

The health care commission, as you know, is the State health planning and development agency for the State of Mississippi and as such handles all of the health planning and certificate of need matters. The

BEST COPY AVAILABLE

health care commission is also the State licensing agency as well as the titles 18 and 19 certification agency for health facilities in the State who participate in medicare and medicaid. The health care commission has a dual responsibility for home health agencies in the State: One, through its certificate of need auspices; and the other one through licensure and certification.

The health care commission has issued certificates of need for various home health agencies in the State in various settings, and also it issues on an annual basis the renewal of the licenses for these agencies. The commission has tried to promote through its certificate of need efforts the dissemination of the type of home health services across the State that would comply both with licensure and certification requirements. However, to date there is a moratorium in place on the issuance of certificates of need for new home health agencies as well as for the expansion of a geographic service area of an existing home health agency. We have noticed that with the advent of DRG's, there seems to be a renewed interest in the provision of home health care, particularly by institutional providers. Since that moratorium is in place and no certificates can be issued, we have noticed that hospital providers, in specific, have become more interested in providing the care through services under arrangement with various other hospital-based providers. Of course, this has been to the consternation of some of the free-standing community based home health agencies. However, providing home health care under arrangement is allowed in Federal certification requirements under certain guidelines as well as in our own State licensing laws and what-have-you.

Now, in our research, however, we have noticed that while we have a large number of home health agencies and we seem to have a very high service volume, particularly in relationship to other southeastern States—and we have noticed that volume increase over time—we have also noticed that much of that volume is characterized by a number of visits to a particular patient. As such, we still feel at the health care commission, through our certificate of need research, that there are pockets of need out there for home health agency services; that some people are not getting these services. Very rural people in sparsely populated areas generally are not getting these services because of the distances from where they live to the home health agency office. Many of the home health agencies are small in nature and not able to undertake the kind of capital costs it would take to establish a branch office in a community and, therefore, they don't feel that the market is big enough to really try and go after that sparse market. We also notice that in certain of the urban areas, particularly in the urban ghetto areas, that many of the blacks who access black providers are not getting these services particularly, because the patients avail themselves of general black providers who don't own or have contracts with existing home health agencies and generally won't refer or are not able to refer their patients to home health agencies; and, therefore, some of these pockets are not being provided, while the agencies themselves do exist.

BEST COPY AVAILABLE

So we think that with the—we hope, rather, that we can ask the legislature—and the health care commission has backed a policy in its State health plan that would call for the removal of that moratorium no later than June 30, 1985, so that we can begin to serve some of these other pockets of need. And, again, we realize we have a large number of agencies, but we also think that the issue of access is still one that's very important, particularly with certain population groups, namely, the very rural and also the urban dweller, particularly those minorities and others in ghetto areas and urban centers.

Senator COCHRAN. Thank you very much, Mr. Pugh.

Let me stop now and welcome Lowell Weicker to Mississippi. We're glad you're here, Mr. Chairman.

Senator WEICKER. It's good to be here. I was thinking on my way, this is the first time I've been to Mississippi, as a matter of fact. It's specifically at the invitation of Senator Cochran that the subcommittee is here.

Let me say this. You have a very gutsy Senator in terms of fighting for appropriations for both health care and education. And I say gutsy, because we operate in a sometimes exceedingly conservative climate and I find it very difficult to find allies to get money for health care and for education.

Senator COCHRAN. Don't help me too much, now.

Senator WEICKER. Not once has Senator Cochran failed to step up to bat for money for these areas. Now, you know, the other day we managed to go ahead and get additional funding, some $650 million for health and $1.3 billion additional for education. You don't have to worry about the defense budget—I might add I represent the biggest per capita defense producer in the country—the defense budget is fine. But, the real security of this Nation is its people, and if those people are in ill health or if they're not educated, we've got bigger problems than whether or not we buy any particular weapon system. It all came home to me, as a matter of fact, last week when I happened to be walking from the Capitol back to my office. We had just gone ahead and voted all these funds for this activity down there in Central America, covert aid and overt aid, whatever you want to have. As I was walking across the park, between the Capitol and my office, there was a young couple with their child in a wheelchair. I guess that boy must have been about 12 or 15 years old; an absolutely lovely looking child, clearly afflicted with some serious malady to the point where the child obviously couldn't speak, couldn't move. And I'll tell you, as I see what we do on the Senate floor for death and destruction and I walk by a scene like that—one that's being repeated over and over again here in Mississippi and everywhere else—I'd like to know what we're doing.

The United States is supposed to be about life, and we have plenty to keep us busy right here, right here in Mississippi.

[Audience applauds.]

Senator WEICKER. And, throughout this Nation, that's why I started off by saying you have a gutsy Senator, because those have been his

BEST COPY AVAILABLE

priorities and consistently his priorities. That's the reason why I like Thad Cochran. Pure and simple. So, anyway, that's the nature of my introduction.

Senator COCHRAN. I think I can survive that.

I know that this is a busy time in Washington and we are taking up legislation later this afternoon and will be busy all week. Your carving out time in your schedule to come down here is deeply appreciated by me and authorizing the hearing under the auspices of your subcommittee is deeply appreciated.

If I may, let me just ask one other question of this panel, and I know there are other witnesses, but something that Dr. Fox mentioned in his statement about the lack of staffing at a lot of the primary care centers, I worry about that and the imposition of requirements for recordkeeping and all the rest that goes with the operation of the centers. Are we putting too much of a burden on these centers and on the personnel? What I worry about is seeing people having to spend most of their time dealing with paperwork, reporting to Atlanta, to Washington, complying with Government guidelines and regulations, doing audits, or having to answer questions all the time and not seeing patients. I worry about somebody dying out in the reception room while somebody's in the back filling in a form, and I really am concerned about that because I think one of the bad parts of this system is that we can just choke it down with so many rules and so much—not harassment but just mandates that we don't get the job done for which the centers have been authorized and funded. What is your reaction to that? Is there a way—can the Government do a better job, the Federal Government, in streamlining these procedures and rules?

Dr. FOX. Well, I have some ambivalent feelings about that, and the centers are probably going to have to speak for themselves as far as their opinion on what they're having to report and the utility of it. I think that, in my opinion, there needs to be some reporting so that you can look at centers and encourage them to be efficient, but I guess what I was talking about in the area of State level support or managerial function is some way to help centers to not duplicate their efforts, to utilize their people efficiently. And we found this in public health departments: That they're generally out there busy; they may not be busy and efficient. And I can't speak for the centers to say whether there is a situation like that, but I think that there is a need to help them utilize what resources they have to the maximum extent; and that is what I see as the need for the centers in this State, and I think they're going to have to speak to that themselves.

Senator COCHRAN. Those are the only questions I have, Mr. Chairman.

Senator WEICKER. But to follow through on the question that Thad asked: As to between the State and the Federal Government, do you find any difficulty in the line of communications or anything that you would improve upon?

BEST COPY AVAILABLE

Dr. Fox. There is currently no State level administrative or any other type of structure for primary care centers. The line of relationship goes from local to Federal.

Senator WEICKER. No State involvement whatsoever.

Mr. PUGH. I would add to that, Senator Weicker, at the health care commission, we are the State licensing and certifying agency for titles 18 and 19 for health standards and quality in the State, and we have purposefully at the State level not added any other regulatory burden on the rural health and community health centers. We have not included them on the certificate of need, we have not sought to develop any licensure requirements or any other certification requirements. Now, we do undertake the title 18 and 19 certification requirements that are required by the Federal Government on medicare and medicaid when a center participates in that program. But we have developed no—and purposefully so—no other regulatory requirements for these agencies to develop and to maintain themselves in the State.

Senator COCHRAN. Thank you very much for the contribution that you've made to the hearing this morning. We appreciate your statements. They have been excellent. Thank you for being here.

COMMUNITY HEALTH CENTER PANEL

STATEMENTS OF:

RON CRAWFORD, EXECUTIVE DIRECTOR, MISSISSIPPI PRIMARY HEALTH CARE ASSOCIATION

CLYDE L. MOCK, PRESIDENT, MISSISSIPPI PRIMARY HEALTH CARE ASSOCIATON; PROJECT DIRECTOR, MADISON-YAZOO-LEAKE FAMILY HEALTH CENTER IN CANTON

DR. RICHARD J. ENOCHS, DIRECTOR, MOUND BAYOU COMMUNITY HEALTH CENTER

Senator COCHRAN. We have another panel of community health center officials, those who are involved in the State association of health centers. Let me invite Ron Crawford, director of East Central Mississippi Health Care, to come forward with Clyde Mock, who is president of the Mississippi Primary Health Care Association; he's also the project director of the Madison-Yazoo-Leake Family Health Center in Canton. Ron Crawford is executive director of the Mississippi Primary Health Care Association. We have others—let's break this down, maybe, into two groups. Let me ask Dr. Richard Enochs, director of the Mound Bayou Community Health Center, to join this group. Then we'll have the others in a second panel who are involved in the community health centers.

I want to welcome you to the hearing. Let me say, before I ask Mr. Mock to lead off in this panel, that we got the idea of having this hearing at a meeting that I was invited to attend by Ron Crawford and Clyde Mock to discuss some problems that were being experienced in Mississippi in these health centers. I met with a group who were here in Jackson, we had a good discussion, and it appeared to me that the thing to do was to try to get the attention of those in Washington who

BEST COPY AVAILABLE

were in key positions who could really make things happen. I can make some things happen but you need help. There are 100 Senators up there and you can't get anything done by yourself without some support. It occurred to me that Lowell Weicker, as chairman of the subcommittee that funds all the activities of the Department of Health and Human Services, and who also serves on the legislative committee that authorizes—therefore, writes the legislation under which these programs are operated—would be the kind of person who needed to hear some of these problems and could help make things happen to improve our health care delivery programs in Mississippi for the rural poor, the elderly, and for those who don't have access, for financial reasons or for whatever reasons, to the traditional hospital/doctor resources that are available.

PREPARED STATEMENT

So it was because of our meeting that this has come about, and I appreciate, again, your bringing some of these problems to my attention. Now let me ask you to go ahead and proceed. I appreciate your being here.

We will insert your statement in the record at this point.

[The statement follows:]

STATEMENT OF CLYDE MOCK

In support of the Senate Labor and Human Resources Committee, under the leadership of Senator Orrin Hatch (R-Utah), chairman that authorized community and migrant health centers through fiscal year 1987 and also repealed the primary care block grant, I am submitting this information.

Included in this presentation is background information on one of the 330 and 329 projects funded in Mississippi. The Madison-Yazoo-Leake Family Health Center, Inc., was initially funded July 1, 1982, to provide ambulatory health care to 10,000 citizens of Madison, Yazoo, and Leake counties, MS. The three county service areas are located in central Mississippi, north of the capital city of Jackson, MS. Madison-Yazoo-Leake Family Health Center, Inc., presently operates ambulatory health facilities in two of the three counties (Madison and Yazoo). The two clinics are staffed with four FTE primary care physicians, one practitioner, and two FTE dentists to service a patient population of 87,752 individuals according to the 1980 U.S. census data.

The clinic maintains 14,480 active medical records charts that represent a penetration into the total population of about 16 percent of the service area. The 1980 census data suggests that our service population in the three counties is about 51 percent nonwhite. In the State, the percentage of nonwhite is about 36 percent and the national average is between 12 to 15 percent. These figures in themselves are unique and suggest that a large percentage of the population would be socioeconomically deprived.

It is public knowledge that Mississippi's educational achievement is last among the 50 States and because of this fact, high technology and other skill industries do not see Mississippi as a vibrant place to establish and/or develop new revenues. One can conclude that Mississippi will continue to receive most of its revenue from transferred Government payments.

Mississippi is rural in nature, resulting in low population density, which means that most citizens have to travel a minimum of 12 to 15 miles to receive health care. In published and unpublished data, the State has a higher percentage of female head of households and extended families. Without continuing Federal dollars to support the 330 and 329 projects, the indigent poulation will not be adequately provided for, because the private sector will not provide overall health care.

BEST COPY AVAILABLE

In the 1983 bureau of community health service common reporting requirement [BCRR], Madison-Yazoo-Leake Family Health Center, Inc., [M-Y-L] reported 11,821 users, of which 20,556 were primary health care encounters (face-to-face) and 4,087 dental encounters with a grand total of 33,641 encounters which also includes nutrition and health education, et cetera.

In the three county area served by M-Y-L 68 percent of the patients served are at or below the poverty level. In 1983, M-Y-L along with the other centers received a supplemental grant to provide health care for citizens who had lost their jobs during the economic recession. Under the jobs bill the center was able to employ an additional physician to provide access to the service population into the health care systems. Over 4,000 encounters were generated under the jobs bill system.

The Madison-Yazoo-Leake Health Center, Inc., present doctors (1 internal medicine, 2 board certified family practitioners, 1 general practitioner), 2 dentists, 1 family nurse practitioner, 1 pharmacist and 43½ other administrative and support personnel.

In Mississippi access to medical services in rural areas is far more difficult than in urban areas. Some of the factors that affect access to medical services are personal income, transportation, and personnel. In rural areas the gross personal income is far less than the urban areas. Personal transportation is often linked to income and public transit is not available; therefore, many people are denied access unless transportation is provided. In small rural areas the health delivery system is not equipped to handle the needs of the population. Rural health centers have problems in attracting and retaining qualified people.

Equal access to quality health care for the poor in this country has been the responsibility of the Federal Government in the past and will continue with our without 330 and 329 funds. Through public funded health centers, the Federal Government has been able to monitor this service and insure that the poor would also receive quality health care.

The Mississippi Health Care Association would like to express its thanks to Senators Weicker and Cochran, and the committee for the public hearing and continued Federal support for 330 and 329 projects. This hearing has allowed one-third of the health programs in the State to address the committee on our concerns about the impending legislation and the effect 330 and 329 programs have had on the health status in Mississippi. On behalf of the association and myself, I would like to state that we appreciate Senator Cochran's concern for the health center movement in Mississippi.

STATEMENT OF CLYDE MOCK

Mr. MOCK. The Mississippi Primary Health Care Association would like to go on record, first, thanking Senator Weicker for calling this subcommittee hearing on public health, 330 and 329 funds, and also would like to say to Senator Cochran that we appreciate his concern for public health in Mississippi and, hopefully, that this bill will go on to the Nation to express not only to the States but to the Nation as a whole that we, as Americans, are concerned about our poor and elderly.

I would like to go on record as talking not about the document that I submitted to you as a director of a primary health care center, but to talk to you as the president of the Mississippi Primary Health Care Association. I would like to say about Mississippi—and Mississippi is the most unique State in the Union, and our uniqueness is something that the Federal Government has never trusted. Mississippi has the largest percentage of black population in the Nation, and when you look at that large population of blacks, you see that the State itself would be socially deprived, not because of racial or any issues that we do not understand, but socially, historically we have forgot about the poor, and Mississippi is a very poor State because of that.

BEST COPY AVAILABLE

And when we look at the primary care centers in Mississippi, most of them are funded in counties with a large percentage of black population. Let us be very candid about that. Black people, throughout the history of this country, have been neglected, for whatever the reason. It's not racial. I thought for a long time that it was racial, but I realized that this is not a racial issue. It's because, as an American, we are all about survival. We have families, we have friends, and when we invest our time and energy in our family and friends, we forget about those who are not like us. And I'd like to go on record to say that this is not a racist country, as a lot of us have said. This is a country all about surviving—surviving of your family and your friends, and you just forget about those who are not like you. I just want to make that statement clear.

We're supporting primary health care in Mississippi because without the primary care centers, the patients that have been served for the last 10 to 12 years, as at Mound Bayou, these patients will have no source for their health care. Health care is an issue that has been spoken about by elected officials, by organizations, for the last 20 years. But what has happened in this country, as we address the needs for health care, the cost for health care has been escalating. Nobody has dealt with the issue of why the cost for health care has escalated. Leaving out the poor, even the middle class people are not allowed any good health care setting anymore. They don't have the dollars to provide health care for their families. We need to look at primary care and we also need to address beyond that something in the private sector to get ahold of costs, because if costs continue to rise—some people have suggested in the year 1990 or 2000, the cost for health care in this country will be reaching the $1 trillion mark. That in itself is frightening to me. If you're providing health care to a nation which will probably be somewhere in the neighborhood of 200 to 300 million people and it will cost $1 trillion to provide health care to those people, that is frightening. And I would suggest to the Congress that they look at not only the public health sector but in the private sector to get some control on costs.

For this, I thank you.

Senator COCHRAN. Thank you very much.

Senator WEICKER. To comment on one aspect that I just touched upon in my opening remarks and what you're talking about: In the last several years when we've had these large reductions in the area of Federal moneys going into health, one of the areas that has been reduced dramatically has been research. The amendment which passed on the Senate floor the other day was $650 million more for biomedical research. Why? How can you ever control health costs unless you, in effect, keep on striving for the elimination of disease. The cost of Alzheimer's alone is billions and billions of dollars. You can go right down—heart disease, and cancer. Obviously, if you can get a handle on this in terms of cures, the economic savings are enormous. We've been cutting off our nose to spite our face around here as we cut back on

BEST COPY AVAILABLE

scientific research and health care costs escalate. No matter how good the delivery system—no matter how good the delivery system, the ultimate weapon is to find the cure. And I hear you talking and the figures are staggering as to what we're going to be paying in the future. And I'm satisfied that the delivery systems, organizations such as yours and those in this room, are doing a darn good job, but the Federal commitment has to be far greater than it is to go ahead and give you the support that you so desperately need in many areas that are beyond your capacity, the research area being one.

Senator COCHRAN. Ron Crawford, executive director of the Primary Health Care Association in Mississippi.

STATEMENT OF RON CRAWFORD

Mr. CRAWFORD. First of all, I would like to say thanks to Senator Weicker and Senator Cochran for being here and their interest in health care and support of the State organization.

Senator COCHRAN. Why don't you move that microphone over closer to you so we'll be sure to hear you.

Mr. CRAWFORD. My name is Ron Crawford; I am executive director of East Central Mississippi Health Care, Inc., which operates a rural health clinic at Sebastopol, MS. I also serve as executive director of the Mississippi State Primary Health Care Association representing 21 federally funded, operational health care projects in our State. I am pleased to have this opportunity to be here today to discuss our health care needs in Mississippi. Since the majority of our Mississippi project are not present, I have been asked to provide a summary of the activities of these projects during the past year.

During calendar year 1983, approximately 121,000 Mississippi residents were users of the primary care centers with a total of 406,010 clinic visits. Fifty physicians, twenty dentists and ten mid-level practitioners provided services through the sponsorship of the projects and a total of 698 persons were employed. Total amount of current Federal grants to Mississippi primary care projects is approximately $11.5 million. By way of comparison to the 1980 calendar year, this represents a 29-percent increase in the number of clinic visits with a 25-percent decrease in Federal funds, adjusted for inflation (3-percent decrease in actual dollars). Most of the persons who received services at these clinics have no other available source of care due to income restrictions, unemployment, distances to other health care facilities and a general shortage of health care providers in our State. These community-based primary care centers are a vital and necessary part of the health care delivery system in our State and we urge your support of the necessary legislation that will ensure the continuation of Federal funds required for their operation.

Specifically, on behalf of the Mississippi Primary Health Care Association, we request your support of Senate bill 2308, as amended, which includes provisions for reauthorization of community and migrant health centers, repeal of the primary care block grant, and an increased

BEST COPY AVAILABLE

role of the State associations in the areas of MUA designations and MOA's with HHS and States. It is further requested that careful consideration be given to increasing the funding levels proposed in S. 2308 to those proposed in H.R. 5602 as introduced by Congressman Waxman.

With respect to our east central Mississippi health care project, it evolved from individual planning grants awarded to the four counties of Newton, Kemper, Clarke, and Jasper in September 1977. These four counties soon realized their health care problems were very similar: medically underserved with a critical shortage of primary care providers; high infant mortality; and a high ratio of poverty-level and minority residents.

Through the joint efforts of the Mississippi Health Systems Agency, the HHS regional office and the four counties, a merger was effected resulting in a central organization formed to develop a consolidated approach to meeting the health care needs of these four counties. Four additional counties of Smith, Scott, Leake, and Neshoba soon joined the organization making a total of eight counties served by the project. Initial funding for the project was received in May 1978, and the development of a rural health care delivery system was started.

The organizational approach to achieving the objectives of the rural health initiative was based upon a fundamental principle of responding to community interest and needs and joint commitments by the communities and the providers. The project assisted in pioneering the concept of delivery of medical care by family nurse practitioners in Mississippi by staffing six rural health clinics with family nurse practitioners. Emphasis was placed on integration of the program's services with existing health care resources through linkages with local hospitals, local health departments, social service agencies, local pharmacies, and referrals for specialty consultation. A centralized management concept was established with a separate administrative office located in Newton at the center of the eight counties.

During the first 3 years of project operation, nine clinic sites were developed, staffed, and began delivering services. Dental services were added later at two of the clinics. In September 1982, direction was received from the DHHS regional office that the project was to be completely phased out within a 90-day period. Joint efforts between the project and the regional office resulted in an agreement that the project would be continued with a reduction to one clinic site at Sebastopol serving portions of the four counties of Scott, Neshoba, Leake, and Newton. In conjunction with this action, the community board of directors was to be reorganized to include only representatives of those four counties. A further condition of the continuation grant award was that the administrative office and staff be relocated from Newton and colocated within the clinic building.

Senator COCHRAN. Thank you very much, Ron, for your testimony.

We're also glad this morning to have Richard Enochs from Mound Bayou, Delta Health Center director. I had the opportunity to visit the

BEST COPY AVAILABLE

center last year, had a tour of that facility which I appreciated very much, appreciated the hospitality on that occasion. Proceed with your testimony and, if you can, abbbreviate somewhat the written——

Dr. ENOCHS. Oh, no, no, no.

Senator COCHRAN. I appreciate this. This is an excellent statement that has been prepared and submitted, and it's a very compelling explanation of the important work being done in a rural health center. You may proceed.

STATEMENT OF RICHARD J. ENOCHS

Dr. ENOCHS. Senator Weicker, Senator Cochran and other distinguished committee members and participants. I wish to express appreciaton on behalf of the Delta Health Center's 17 member board of directors, its 207 member professional and lay staff and its more than 22,000 active patients for being invited to testify before this committee. This opportunity gives us a chance to tell first hand, the appropriations subcommittee that the money appropriated for community health centers in Mississippi is well spent and it is providing a health care service that is unquestionably needed and without it, many deserving American citizens would go without health care because of economic inaccessibility to the public or private sector. Many of these citizens are individuals who fall within the enormous crack that exists between affluence and poverty. Even the middle class finds itself in a pool of economic quicksand. Although many of them meet the economic criterion for various assistance programs, other moral and legal criteria effectively eliminates this group. I am suggesting that the safety net be rewoven so that it can effectively catch and serve all Americans who need and deserve health care and other services.

The Delta Health Center opened in the fall of 1967. It came into being through the efforts of Dr. Count Gibson, head of the department of preventive medicine, Tufts University and Dr. Jack Geiger, professor in the department of preventive medicine, Tufts University. The center opened as the sister facility to Columbia Point Comprehensive Health Center, Boston, MA. Drs. Gibson and Geiger were able to receive funding from OEO for two projects, one rural and the other urban, to demonstrate that an ambulatory health facility could function as a Health Maintenance Program as well as a Disease Prevention Program.

During the last 16 years, Delta Health Center has provided health care services to more than 70,000 different patients accounting for approximately 1.6 million service encounters including its Home Health Program. The current patient population categories provided services by the center are as follows: 14 percent medicare; 11.7 percent insurance and self-pay; 10 percent medicaid; and 64.3 percent below the poverty guidelines. Clearly without PHS section 330 funds, some 14,146 persons accounting for more than 113,000 encounters would sit home without medical care. Certainly, the present system has not nor can it absorb those persons.

BEST COPY AVAILABLE

In the early 1970's, Delta Health Center provided jobs to 396 community lay and professional persons. As of today, this has been reduced to 207. With a budget of approximately $5 million, of several key towns and cities in the area.

IMPACT OF CENTER ON HEALTH STATUS IN AREA

Approximately 97 percent of the patients served by Delta Health Center are black. Four of the leading methods of assessing a people's health status are mortality, longevity, prevalence of disease, and disability. Applying these measures to the center's patients, we found: One, infant mortality from 1970 to 1977 among nonwhites declines 37.5 percent from 39.7 per 1,000 to 24.8 per 1,000; two, maternal deaths among nonwhite women from 1970 to 1976 decreased from 125 per 1,000 to 19.6 per 1,000; three, the prevalance of disability in the State of Mississippi is 42.1 per 1,000 compared to a national level of 31.2 per 1,000; four, the 10 leading causes of death in Mississippi for 1982 still represented 80.5 percent of all causes of death; and five, the elderly population, 65 and over, in 1970 increased from 222,320 to 269,000 in 1978.

Considering the above statistics the Delta Health Center has made a great impact on the health of the target population. Declines in infant mortality, maternal deaths, life expectancy, and several other leading causes of deaths have occurred in our target area between 1970 and 1982. Comprehensive health centers, rural health initiatives, and urban health initiatives have played a major role in improving the health status of the target population.

Other significant benefits that Delta Health Center and other community health centers have contributed to community and human development include their role in increasing the health manpower pool by serving as training grounds for students. They have also served as magnets to attract providers back to our communities. This role has been especially critical in increasing the number of minority providers in underserved communities.

These accomplishments have been achieved through the handiwork of a dedicated staff who often work for several years without pay incentives. They are, however, committed to the concept and philosophy of community health centers and closely in tune with the needs of the community. Along the way, we had our growing pains and because of our location, we continue to have problems related to the recruitment and retention of physicians and some other key professional staff. Our providers are not welcomed at many area inpatient facilities. We continue to get new patients with limited resources, but are expected to provide the service without regard for our inability to get additional funds.

The future for Delta Health Center and health services to the underserved in the Mississippi Delta is bright, provided adequate funding is provided. It is the only place in the area where a patient may receive comprehensive medical and health related services under one roof at a

BEST COPY AVAILABLE

cost comparable to one's resources. Its modern physical plant provides aesthetic and pleasant atmosphere for receiving some 12 different ambulatory services ranging from foot care to counseling.

Senator Weicker and Senator Cochran, first of all, just to comment on the paperwork. Our budget submitted 3 weeks ago approached 2,000 pages, and if 600 to 800 other health centers around the country are doing that, the Federal agencies are going to have to buy some additional paper shredders, I'm sure.

We also like to think that we provide a very effective health care service because we feel that our management team is one of the best there is.

Thank you very much.

Senator COCHRAN. Thank you for an excellent statement, Dr. Enochs. I think you've clearly indicated with your presentation what this program has meant to a lot of rural poor in Mississippi, a large number of people who would not otherwise have access to any medical care.

I wonder if this panel could provide any information to the committee about improvements that could be made in the licensing or review of centers, applications for licensing, since you do represent all of the health care centers in the State—primary health care centers. Are there any items of information that you think would be helpful to the committee to know? Could we improve legislation, since it is up for reauthorization in that area?

Mr. ENOCHS. I have a history of the health center which I would like to include in the record.

[The information follows:]

BEST COPY AVAILABLE

DELTA HEALTH CENTER

HISTORY

The Delta Health Center opened in the Fall of 1967. It came into being through the efforts of Dr. Count Gibson, head of the Department of Preventive Medicine, Tufts University and Dr. Jack Geiger, Professor in the Department of Preventive Medicine, Tufts University. The Center opened as the sister facility to Columbia Point Comprehensive Health Center, Boston, Massachusetts. Drs. Gibson and Geiger were able to receive funding from O.E.O. for two projects, one rural and the other urban, to demonstrate that an ambulatory health facility could function as a health maintenance mechanism as well as a disease prevention mechanism.

The impact on the health of residents in North Bolivar County was immediately seen. Many of the poor in this area did not have a doctor—most of the residents have never visited a doctor. So the first six months of the Center's existence were spent treating diseases. Soon it began to dawn on the medical providers that many of the diseases they were treating were caused by environmental factors. Treating the disease was like smoothing the surface while the underlying causes were untouched.

As a remedy for this problem, the Center hired an environmentalist, Mr. Andrew James. Mr. James organized the Environmental Health Department. In researching the communities to find the environmental causes of the various diseases listed under environmental causes, the department found an alarming number of environmental factors that breed causative organisms. Among some of their findings were improper or lack of insect controls, improper or lack of waste disposal facilities, impure drinking water, and housing so poorly constructed that sleeping in the open would have been just as healthy. These conditions existed among the poor in both towns and rural areas. It took about five years for the department to solve these problems.

The next problem faced by the new Center was infant mortality. In 1968 the infant mortality rates in Mississippi were for whites 22.7/1000 live births, and for nonwhites 47.8/1000 live births. The rates for Bolivar County was shown that year, but certain

BEST COPY AVAILABLE

peculiarities of Bolivar County's population suggests that the county rates were either more than or equal to the State's rates. Bolivar was and still is rural with over 50 percent black of whom 87.5 percent is below the poverty level.

Assuming that Bolivar County's infant mortality rates were similar to the State of Mississippi rates, infant mortality rates in Bolivar County in 1968 were 22.7/1000 for whites and 47.8/1000 for nonwhites. In 1978 the infant mortality rates for whites in Bolivar County were 15.0/1000 and the rates for nonwhites were 30.2/1000 . The differential of 17.6/1000 live births shows the impact the services rendered by Delta Health Center had on infant mortality among blacks.

In 1968, Dr. Florence Halpern, a clinical psychologist, conducted a study under the auspices of the then Tufts Delta Health Center. Dr. Roy E. Brown, a pediatrician and epidemiologist, concerned with the relationship between nutrition and mental development designed the study. The lack of adequate funding prohibited the study being carried out as originally designed. Nevertheless, a cross sectional study was substituted.

A total of four hundred and two black children, ages 36 months and below, were given medical examinations. On the average the black children were somewhat below norms established for white children in regard to anthropometric measurements. They were practically all anemic, some mild, some severe. However, there were no cases of Kwashiorkor or marasmus.

Only 344 children received the psychological test, the Gesell Developmental Scale. The average D.Q. for the 344 children, 175 boys, 169 girls, was 95.98, practically 96, with a range from 50 to 179. Using a D. Q. of 100 as the norm, the children tested very close to the norm, and certainly scored within the normal range.

Testing these children at 3 months intervals, the findings show that at 36 months of age the average D.Q. for the 344 children dropped from 95.98 to the middle 80's.

When the test results were broken down into the four areas defined by Gesell, namely: motor, verbal, adaptive and personal-social;

BEST COPY AVAILABLE

it is the verbal that shows the earliest and severest impairment. Only 23% of the children showed a verbal development in line with or above expectancy for their chronological age, whereas in the three other areas close to half of the children score in line with expectancy.

Perhaps most significant of all is the absence of any correlation between the results of the psychological tests and the physical findings. In view of this it was felt that the drop in D.Q. that these children manifest, especially their verbal limitation, are due as much to cultural impoverishment as to nutritional deficit.

Although the evidence above did not prove conclusively that brain damage occured from milnutrition, other physical evidence point out the children are somewhat underweight and below normal height, and that all but ten of them suffer from anemia, constitutes sufficient evidence of their need for nutritional help.

Based on evidence presented in this study and other studies, the project was able to begin a supplemental food program that we believe is the forerunner of the WIC Program.

The forerunner of our present Health Promotion and Disease Prevention Program was the old Community Health Action/Education Program initiated by Dr. John Hatch. The underlying purposes of the program were to present a health care program to a hardcore population and change their lifestyles.

The program was successful in that it established health councils in communities all over North Bolivar County. Each Health Council rented a building which serviced as a meeting place as well as a place where health education could take place. Immediately after its inception each building became a feeding place for the elderly. The outreach activities of the Health Councils were responsible for much of the success of the old O.E.O. sponsored program.

Portions of our present Health Promotion Disease Prevention Program are derivatives of the CHA/E Program. Family planning, health education, environmental health, infant and pregnancy care, immunization, hypertensive care and dental services were some of the preventive and protective services.

40-415 O - 86 - 3

BEST COPY AVAILABLE

Presently, health care plans have been made that cover many of the health promotion, prevention and detection services suggested by the U.S. Department of Health and Human Services.

The Center has taken an active roll in the State Health Care Planning Program at both the local and state levels. Some Center personnel who have taken an active role in state health care planning are Dr. Willie B. Lucas, Dr. Warren Inge, Dr. Luther McCaskill, Dr. Richard Enochs, Center Director and Ms. Norma Brooks.

Our purposes reflect the purposes and goals of the Mississippi Health Systems Agency. The MHSA states its purpose is to provide effective health planning, including development of health services, manpower and facilities which meet identified areas' needs. The health planning law assigned the MHSA the following four major goals:

1. improve the health status of the area residents;
2. increase the accessiblity, continuity and quality of health services,
3. restraining increases in the cost of health services; and
4. preserving and improving local health care competition.

The MHSA's Division of Planning and Research in conjuction with the Division of Plan Implementation and Coordination conducted meetings in each of the ten (10) local subarea advisory districts from October 4, 1983 to October 13, 1983. The purpose of the meetings was to involve members of the local subarea advisory councils and other interested persons in selecting the three most important health problems in their area to be included in the upcoming Annual Implementation Plan. Well over 300 persons participated in the process. In the South Delta SAC the results of the area's selection process are as follows:

1. Hypertension (High Blood Pressure)
2. Teenager Pregnancy
3. Heart Condition

We believe that the Health Center has played an important role in improving the health status of our target area residents. There are many ways to assess the health status of people. Mortality, longevity, prevalence of disease and disability are the measures

BEST COPY AVAILABLE

most commonly used. Listed below are some recent statistics related to these indicators. Although the statistics are statwide, the same results are reflected in the South Delta SAC.

I. Improve the Health Status of Area Residents

A. Gains in life expectancy - The total life expectancy in the United States increased by 2.95 years or 4.1% from the 1969-71 period to the 1979-81 period, whereas Mississippi's total life expectancy increased 3.85 years or 5.6% during the same period. The current life expectancies for the United States and Mississippi are 73.7 years and 72.15 years, respectively.

B. Infant Mortality - The total number of infant deaths in Mississippi has decreased by 70% from 1950-82 and 42.1% from 1970-80. Significantly, the decrease in nonwhite infant deaths in Mississippi has been similarly during the 1950-82 period, with percent declines of 71.2% and 41.4%, respectively. The 1981 infant mortality rate of 15.4 is 9.4% less than the 1980 rate, 31.6% less than 1970 rate, and 62.9% less than the 1960 rate.

C. Maternal Deaths - In 1950, Mississippi had 165 maternal deaths in 1970, and 1 maternal death in 1982. These statistics represent percentage decreases of 99.4% from 1950 to 1982. Maternal deaths are deaths resulting from deliveries and complications of pregnancy, childbirth, and the puerperium.

D. The Leading Causes of Deaths - From 1970 to 1982, five of the ten leading causes of deaths in Mississippi (cerebrovascular disease, accidents. pneumonia and influenza, diabetes mellitus, and certain conditions in perinatal period) have recorded decreases in the total number of deaths. However, the ten leading causes of deaths in Mississippi for 1982 still represented 80.5% of all causes of deaths.

BEST COPY AVAILABLE

Mr. CRAWFORD. Dr. Enochs touched on his application which is about two Sears catalogs thick, I think, and there should be, in our opinion, some consideration given to the smaller programs having a streamlined application process, and we would support the regional office. The regional office is making efforts to give a 3-year project period. Approve a project for 3 years. That doesn't mean 3 years' funding but it would be approved and in the subsequent years would get a simple streamlined application. It doesn't seem quite fair, I guess, to us to take—Dr. Enochs' is probably one of the largest facilities in the State with, he said, about a $5 million budget. We have others with maybe a $200,000 budget that has to go through the same application process that he does and they don't have the facilities. The regional office is, I understand, working on approving a grant for 3 years and then updating it once a year.

Senator COCHRAN. But right now the rule is that you have to be reauthorized or relicensed every year?

Mr. CRAWFORD. Yes, sir.

Senator COCHRAN. And you go through——

Mr. CRAWFORD. The same process.

Senator COCHRAN [continuing]. The process of submitting a budget. What all is in that? Why does it look like a Sears and Roebuck catalog?

Dr. ENOCHS. This year we are under the new review process. We have to submit all of your protocols for your providers, you have to submit your bylaws, your policies and procedures, your job descriptions, the whole bit. And may be after this year——

Senator COCHRAN. What if it hasn't changed? I mean you do this every year. What if it hasn't changed? It looks like we would have some way to say "no change" in that place.

Dr. ENOCHS. Well, that provision was made; however, to make sure that there was no problem, we submitted it this year so next year we could say it was in the 1984–85 application.

Senator COCHRAN. Just adopt it by reference to the previous application.

Dr. ENOCHS. Right.

Mr. CRAWFORD. If I could comment: Part of the change we had there, the regional office made a change in the review process. They went to an objective review that involves—and Mr. Waterhouse might correct me on this—three people that are objective that know, the way I understand, nothing about the project, so everything that was going to be reviewed had to be in the application. And that's been a concern to us in the association, too, is that the application process now is going to be based on reviewing the application, what they have in front of them, rather than the project and the services it delivers.

Dr. ENOCHS. And what this does, it goes back to when the program first started. You notice I said Tufts University started the program at Mound Bayou. Well, Dr. Geiger is a very good grantsman. Had—well, in those days it was different, but now if you do not have or if you cannot employ the services of a person who can write, because of the new

BEST COPY AVAILABLE

process, you may get turned down irregardless of the need for the services that you are proposing.

Senator COCHRAN. So a facility that does not have a staff with someone who is a good grantsman might not get funded next year.

Dr. ENOCHS. That's correct.

Senator COCHRAN. What would you recommend to the committee as a way to keep a clear injustice of that kind from occurring?

Dr. ENOCHS. Well, some variation of the system we've used in the past, I think, could work and it has been working. In the past, you've had the project officer in the review process and you've had other agency staff people there, Federal people, who were somewhat familiar with the project, and if there were questions that arose, you could respond to those questions. The way I understand it now, they will strictly go by what's on paper with no input from the program staff or the staff at the regional office.

Senator COCHRAN. We're going to have to closely monitor that process to be sure that we don't get shortchanged here in Mississippi, aren't we?

Mr. CRAWFORD. I think, again, if the project would say that, on a continuation application, the project has already been delivering services, that the regional office has, probably, substantial data already gathered before we turn the application in to determine whether that project is succeeding or not, and more of that ought to be based on what the actual project does and what has been the performance of that project rather than what they've got on paper. Now, on a new application, it's something else. But on a continuation, they pretty well know how we are without looking at the application. But right now we've been advised that the application will be the source document for funding or not.

Senator WEICKER. I have several questions that I would like to pose to this panel—and I might add to those that follow—which gets to the heart of at least one of the matters before this committee. In testimony before the subcommittee, several of the health directors of major American cities indicated that they were having a great deal of difficulty with the cutback in funds for prenatal care and that it was directly reflected in the infant mortality statistics. I realize that, nationwide this is a matter that's improving, but certainly the impression that I got in my hearings was that among the poor, at least in the major American cities, the cutback in funding, and especially for prenatal care, has had a clear cut negative impact on infant mortality in those constituencies, and I have to wonder—if that's the case among the poor in the cities, what the experience has been among the rural poor. I notice the statistics that you give in your testimony are cut off as of 1978, they run from 1970 to 1978. What has happened in the last 2 to 3 years? That is really of greater concern to me.

Mr. ENOCHS. Well, this year, for example, we've experienced, the last 2 to 3 months, approximately a 10-percent increase in our patient load in the zero percent category, and that's attributed directly to the fact

BEST COPY AVAILABLE

that medicaid cut back in services, so these people lost their benefits and then they came to the health center. But overall, I don't have those figures with me.

Senator WEICKER. Well, let me say this again to bring it back to my own State: We had testimony from the community health center directors in Connecticut that indicated that the number of people being served continues to increase although Federal funds have declined. I want to know if that's true or not down here.

Mr. CRAWFORD. It's true.

Dr. ENOCHS. That is true.

Senator WEICKER. If it's not, I'm going to get you fellows to go up and get the Federal funds, because that's our story in Connecticut. What's the story down here?

Mr. CRAWFORD. From 1980 to—like I said, from 1980, we've had—I think it is a 25-percent decrease in Federal funds for the programs here.

Senator WEICKER. And what's been the increase of your patient population?

Mr. CRAWFORD. Twenty-nine percent increase.

Senator WEICKER. I would like to know how they are being better served. I don't understand that. This is what I have to fight in Washington. This is your chance to speak up on the issue. It seems to me to be rather key in the sense of what it is you're trying to deliver.

Mr. MOCK. I think in Mississippi, the same figures that you see in Connecticut and New York will not apply here because of our uniqueness and because of the commitment from the Mississippi Primary Care Health Center directors as we meet every month to discuss these problems. I think we have a control or grasp of the problem here because we're so small we can do that. In the large cities, it's impossible and it will have an effect on infant mortality rates in the big cities as opposed to Mississippi.

But as the years go by, as medicare is being cut and these programs are being cut, then we will see an increase over the next few years somewhere down the road, about 2 or 3 years from now; that the infant mortality rate will begin to go up.

Senator WEICKER. Well, how are you coordinating your activities—let's say with the maternal/child health funds and the WIC funds, how is that coordinated?

Mr. MOCK. Approximately 80 percent of the centers, the primary care centers, have a contract with the Mississippi State Department of Health for WIC services, and we also interact with the local health departments in referring patients into the Maternal and Infant Program if there is not a OB–GYN on board or a contract with a OB–GYN in a urban setting.

Senator WEICKER. Are you satisfied with the extent of prenatal care that's being given at the present time?

Mr. MOCK. In Mississippi?

Senator WEICKER. Yes.

BEST COPY AVAILABLE

Mr. MOCK. No.

Senator WEICKER. Since we have the media here, it's a subject that I'm sure the public may not fully comprehend. There is a direct relationship in terms of infant mortality and when it is that the mother is first seen by the health facility. In many instances, at least in these other places, the first time they're seen is when they come in for delivery of the child. That's what creates the problem. And there has just been a tremendous cutback in this area of prenatal care. It seems to me to be a very crucial part of the scheme.

So you would like to see additional funding in that area, prenatal care.

Mr. MOCK. Right.

Dr. ENOCHS. One of the problems that community health centers experience is being able to provide continuity of health care. Now, in the rural areas, in Mound Bayou in particular, we had a hospital to close, and although we have maternal and child health money which we work through the State health department, our providers provide the prenatal care at the health center; but when the patient goes to deliver, we're not able to—our providers are not able to follow up because they do not have privileges at those facilities. And that's probably true for some of the other health centers, which creates a problem of continuity which is very key in the health status of a population.

And one of the things that we think we've been very effective in doing, especially Delta Health Center and some of the other projects, we've been able to link up with many of the other federally funded programs to provide a more comprehensive service that affects health care but is not directly related. For example, of course, the State health department, we work closely with. Mental health, Council on Aging, community action programs. Of course, we have a comprehensive transportation system now. Head Start Program, summer youth programs. So we are able to refer and take referrals from these programs and provide a more total comprehensive service to the overall community.

Senator COCHRAN. Thank you very much. I'm going to suggest now that it might be appropriate to take about a 10-minute break—and I know the reporter will appreciate that—and give the news media, if they would like, an opportunity to ask questions, if there are any, and then we will resume with our second panel of primary care center directors and then the home health agency representatives.

[A brief recess was taken.]

BEST COPY AVAILABLE

COMMUNITY HEALTH CENTER PANEL

STATEMENTS OF:

HAROLD SPEES, DIRECTOR, NEW HEBRON RURAL HEALTH INITIATIVE

MS. KAYE RAY, DIRECTOR, SOUTHEAST MISSISSIPPI RURAL HEALTH INITIATIVE

DR. AARON SHIRLEY, DIRECTOR, JACKSON-HINDS COMPREHENSIVE HEALTH CENTER

Senator COCHRAN. If the hearing could come to order, we'll continue with our panel of witnesses representing the Community Health Center Program. We have Mr. Harold Spees, director of the New Hebron Rural Health Initiative; Ms. Kaye Ray, director of Southeast Mississippi Rural Health Initiative; and Dr. Aaron Shirley, director of the Jackson-Hinds Comprehensive Health Center here in Jackson. Ms. Peterson of Clarksdale was invited, but is not here.

Senator COCHRAN. Why don't we just start with Kaye Ray and we'll go that way. Welcome.

STATEMENT OF KAYE RAY

Ms. RAY. Thank you. Mr. Chairman, Senator, I'm Kaye Ray. I'm director of southeast rural health office in Seminary, MS.

Major inadequacies in the provision of primary health care services have been identified throughout the Nation, particularly in rural sparsely settled communities. While deficiencies exist in the number of providers and service facilities, the problem of maldistribution of these and other health resources result in a problem of even greater magnitude.

The rural health initiative, under the U.S. Public Health Service, Bureau of Community Health Services, offers the means to bring existing resources together with a common focus and to develop additional resources under a central managment directed toward providing a total program of primary health care. Emphasis, by this definition, is placed on expansion of service capabilities in coordination with existing agencies and the medical community. Realizing that Mississippi is predominantly rural, characterized by low indicators of education, income, and health resources, it follows that rural health initiative serves a great demand for primary health care services.

Southeast Mississippi Rural Health Initiative, Inc. is a private nonprofit corporation chartered for the purpose of improving primary health care in a seven county area in the southeast portion of the State. These counties include Forrest, Covington, Marion, Pearl River, Lamar, Perry, and Jeff Davis. The organization began in November 1978 under a planning grant, which provided for a detailed evaluation of primary health care needs within these seven counties. Three communities within the area of evaluation were found to have significant primary health care deficiencies. The towns of Sumrall (Lamar County), Seminary (Covington County), and New Augusta (Perry County) were thus chosen for inclusion in an operational grant application as potential clinic sites. Within an 18-month period, the three sites selected were

BEST COPY AVAILABLE

providing a full range of primary care services. The Sumrall clinic, staffed by a physician, opened in March 1980; the New Augusta clinic, staffed by a family nurse practitioner, opened September 1980; and the Seminary clinic opened in August 1981, staffed with a physician.

Linkages have been formed with the main providers of health or health-related care, among which are the public health department, Pine Belt regional mental health and retardation complex, county welfare departments, and the Southeast Mississippi Air Ambulance District.

Together, with these groups, resources have been combined to deliver primary care in the most comprehensive fashion possible. Services to these linkages include: Diagnosis, screening, and treatment provisions; medical consultation and referral; diagnostic laboratory services; health education and preventive health programs; emergency medical treatment and transportation of acutely ill or injured patients; and assistance in obtaining pharmaceuticals.

The service area (population total 31,935) respective to each clinic site may be generalized as the entirety of Perry County for New Augusta, all of Covington County for Seminary, and the north half of Lamar County for Sumrall. The most recent BCRR report (January 1, through December 31, 1983) reflects 3,580 users for a total of 14,595 encounters. Continued growth at all three sites has been the trend. The 06 year application addresses this growth in that physician services for New Augusta have been requested and a separate application has been submitted requesting funds to provide for expansion of primary health care services to include primary care dental services in Lamar and Perry Counties.

Goals addressed in the 06 year application were: (1) To continue to provide access to the indigent and underserved residents of the services area to medical and dental care (26 percent of the patients of our agency qualify for the adjusted fee method of payment, 25 percent are medicaid, 15 percent medicare, the remaining 34 percent are private pay); (2) to provide all services in an efficient and effective manner; and (3) to ensure that quality services are provided to clinic patients.

I urge your support of Senate bill S. 2308, as amended, and to consider the funding levels of House bill H.R. 5602. With this continued support, our common goals may be met.

Thank you for this opportunity.

Senator COCHRAN. Thank you very much, Ms. Ray, for the excellent statement and for being here and helping us out with our hearing this morning.

We next have Mr. Spees. We would ask you to proceed.

STATEMENT OF HAROLD SPEES

Mr. SPEES. I would like to tell you how much of a privilege I consider it to be here before you, and I would like to just make a few ad hoc comments, some of which will address some of the earlier testimony from other witnesses.

BEST COPY AVAILABLE

Allow me to start by saying who we are, telling a little bit about the historic strengths that I think are inherent in community health centers and need not be tampered with, and some of the frontiers that we're facing as primary care centers in Mississippi.

We are the South Central Mississippi Rural Health Association. We're a network of three primary health care centers serving Simpson, Lawrence, and Jefferson Davis counties. Last year we saw about 27,329 encounters. We've been historically associated with a black-led Christian humanitarian organization called the Voice of Calvary Ministeries, and because of that, we have seen—we have approached the development of primary health care centers as one strategy of overall community development and have seen that it is an effective threshold for community development in the communities of need that we serve. What I mean by that is that primary health care can be that felt need the community can mobilize itself around and can be the launching pad for a number of other different programs in the area.

Just one example that took place yesterday: We were pleased to be able to move a family with a mother, father, and six children into a used, renovated trailer with a low-interest loan from a newly formed nonprofit subsidiary called Rural Services, Inc. The loan was for $900 that they'll pay off $50 a month and they'll have housing that—last Christmas I stood in their house, the wind was literally whistling through the cracks that were obviously visible in the walls of the house. And I use that as an example of a spinoff type of implication for community health centers in the communities that we serve.

This ties into what I would like to address in terms of historic strengths. I think the community board structure of the community health center is very important and is vital, in fact, to the type and quality of care that we give. It has many spinoff results, and what you have by nature is a public/private sector partnership, because we are first and foremost nonprofit organizations chartered in the State of Mississippi with community boards made up of citizens from our local communities. This offers an ongoing stability and support and it has direct implications in terms of professional retention and targeting resources to the areas that they're needed most.

The second historic strength is in the area of health promotion, and I think that the community health center's commitment to treating the whole person in the context of their whole environment is making a difference in terms of just attacking acute problems or specialized problems like the health department with its more epidemiological approach. I don't want to put one over against the other, but, in coordination, an epidemiological approach as used by the health department and a total needs approach as used by the community health centers can be very effective in attacking some of the problems in our communities.

In terms of frontiers, I see several frontiers that are going to offer real opportunities for us as community health centers. One is in the area of specialty needs. More and more, we are seeing the need for specialists in our rural communities. We have three family physicians and

BEST COPY AVAILABLE

two family nurse practitioners. We do a lot of prenatal care. Our rub comes when a busy family physician is asked to do a lot of obstetrical care, and so the result is that in Lawrence County, for instance, where we are the only OB care, and in Jeff Davis County, where we provide the only OB care, we just cannot see all the patients that need to be delivered in our local hospitals. And in Lawrence County, for instance, last year there were 250 patients that delivered babies who were residents of Lawrence County. Only 77 were able to be delivered in the local hospital, mainly because of a combination of needs: One, the inadequate staffing that we have to deal with that. Ours are family physicians and they have a tremendous number of other demands upon them. And, second, the hospital just cannot handle the number of indigent patients that we would like to refer to them. And, so, many of these get referred long distances and this cuts down—we believe this cuts down the quality of care.

So I think in terms of specialty needs, those need to be addressed. We are in the midst of a feasibility study to talk about a Maternal and Child Health Program based out of not a large thing, statewide or anything, but just really very local and appropriate technology oriented in terms of the counties that we serve. This is an area where the linkages that are so important to primary care centers come in. We've had some tremendous linkages with other primary care centers and the State department of health. We have a WIC contract to deliver certification services similar to those delivered in health departments and now we're in this approach to a maternal and child health network where we would be recruiting two OB's for four very rural counties to set up a birthing center adjacent to one of the local hospitals. We have received a commitment from the health department to contract with us to do the obstetrical care services in their health departments in those counties. And that's a very exciting melding of the epidemiological strengths in the approach to the health department and the individualized care that primary care centers give. I think linkages will be an important frontier in the future for primary care centers.

One of the dangers that I see happening in the midst of recent shifts in emphasis in administration and what-have-you is the increased emphasis on local professional associations and their oversight, or their comments, about primary care centers. This, if we aren't careful, could butt into a conflict of interest where local professional organizations or associations are asked to give comments about primary care centers that they may view as detrimental to markets that they serve, and it's a very difficult problem. I think that it's a problem in some ways that's been solved, or at least been dealt with creatively at one level, with the model that's been set up with the Governor's primary care working group. The Governor's office has called together representatives from the State department of health and the primary care centers, and because of that continual working relationship, I think the relationship between those two groups has been smoother than it has been in years.

BEST COPY AVAILABLE

Addressing an issue that came up earlier in terms of the need for technical assistance in small primary care associations, there is a need for that. However, there are creative ways to do that, and I think that one of the ways to do that would be to provide limited funds for the primary care association to begin to broker their strengths within primary care centers to each other and also to utilize the assistance of various departments and organizations in the State. The primary care association, I think, would be most able to do that related to issues of grantsmanship, to quality care, the whole waterfront of issues affecting primary care centers. And my emphasis here, of course, is if funds would be provided, that they should be provided through the primary care association to provide this technical assistance and this brokering that would have a tremendous impact.

I guess my last statement is somewhat unrelated but I think it's important as I look out at the frontiers of health care in terms of the primary care setting, and that is the whole need for a private sector initiative. It used to be in our communities that local physicians assumed that they would take 25 percent—10 to 25 percent of charity work, and now with the advent of medicaid and medicare, the assumption now is in terms of a private physician looking at his or her practice as a ladder of success, one of the important steps in that ladder of success has come to be the day that I can, as a private provider, turn down medicaid patients for my practice. And one of the difficulties that we have is gaining access, especially in the specialty areas, to private providers who will accept patients who either aren't covered by medicaid, who are indigent, or patients who are covered by medicaid, and this is a tremendous need. And there is a need—I don't have any answers for that problem, but there is a need for a private sector initiative to resensitize private providers to the need to begin to pick up some of the patients on charity care. I know this also affects hospitals. Hospitals are—we see—sometimes we use the term sloughing, and the issue of sloughing patients and the lack of access that we have to some of our hospitals is a real barrier to some of the needs that we see that need to be met out in our communities.

Thank you very much.

Senator COCHRAN. Thank you very much, Mr. Spees. We appreciate your being here and your testimony.

Dr. Aaron Shirley, a pediatrician and project director of the Jackson-Hinds Comprehensive Health Center.

STATEMENT OF DR. AARON SHIRLEY

Dr. SHIRLEY. Thank you very much, Mr. Chairman, Senator Cochran, and staff.

My name is Dr. Aaron Shirley, I am a practing pediatrician and project director of the Jackson-Hinds Comprehensive Health Center.

I appreciate this opportunity to come before your committee and share with you my views on the health needs of the poor in Mississippi and the contributions being made by community health centers and

BEST COPY AVAILABLE

rural health initiative programs in the State. I mentioned my position as project director of a health center, I also serve as chairman of the board of the Mississippi Medical and Surgical Association, an affiliate of the National Medical Association. Our association is keenly aware of the problems faced by the poor and near poor in obtaining health care in our State and strongly supports the health centers approach to solving these problems.

Large numbers of our State's population have historically been denied access to the traditional health services system. Poverty, race, rural residence, and hostile environmental conditions have served as powerful barriers. Over, 587,000 or 24 percent of the State's population have incomes below the poverty level. About 37 percent of the State's population is nonwhite. Over one-half the population live in rural areas. A recent survey by our health center of rural Hinds County (the county of the State Capitol) revealed that 34 percent of 228 households surveyed had no running water in the home and 25 percent had outdoor privies. Four percent had no toilet facilities at all. Each of these factors is interrelated and the combination of these barriers has had a definite impact on the health status of our people. This is especially true of minorities and of the poor living in rural and inner city areas. These factors have definitely contributed to the discrepancy in infant mortality of whites and that of blacks. Statewide the rate 11.1 per 1,000 live births for whites versus 23 per 1,000 live births in blacks. Rural counties with high percentage black populations consistently show higher infant mortality rates.

Thoughtful health professionals have come to realize that if the cycle of poverty-related illness is to be broken, a more comprehensive approach in the delivery of health care is required. The community health center and rural health initiatives operate on the theory that, in order to really improve the health of poor people, the definition of primary care and its delivery must be broad enough to encompass a host of vital services that must include, in addition to the normally expected physician, nurse team, such services as improvement in environmental conditions, nutrition counseling and support, transportation, social services with special emphasis on improved parenting skills, mental health counseling, general health education, and outreach.

Clearly, over the past 10 to 15 years community based federally funded health programs serving the underprivileged in this region have been alleviating many of the barriers cited above, at times in the face of massive resistance from the States. These programs have proven effective against the barriers of poverty, race, and rurality where they have been implemented in accordance with appropriate Federal regulations and guidelines. For instance, a study of two rural counties in Mississippi documented dramatic reductions in infant morality rates in communities served by these programs.

In one county, the infant mortality rate dropped by 40 percent over a 4-year period following the establishment of community based programs which focused on providing ambulatory, preventive, and health

BEST COPY AVAILABLE

maintenance services, while rates in neighboring counties remained essentially unchanged.

In another county, the infant mortality rate for blacks, most of whom were users of such a program, declined by 38 percent, while the rate for white nonusers actually increased.

One study found that a greater percent of users at a rural community based primary care facility had a regular physical examination than was true of the entire target population. Moreover, minority group users had fewer chronic conditions than the nonuser minority population.

With respect to quality of care, Albert Einstein College of Medicine, which evaluated comprehensive health centers, under the direction of Dr. Mildred Morehead—indicate higher quality of care ratings for community health centers than 10 medical school affiliated hospital departments and 7 group practices she sampled.

In short, the community health center approach has proven to be an effective model for the delivery of health care in both middle class and low income communities. It has been effective in access, delivery, and cost.

The accomplishments of the health centers in this State and region have not come easily. For many years there was suspicion and distrust on the part of State officials. In some instances even officials of the HHS regional office have had doubts as to our legitimacy and our abilities. I am pleased to report that these particular problems have been substantially diminished over the years as we have worked side by side and in some instances jointly with State health agencies in providing care for the poor. At the regional office level we have established a primary care task force made up of representatives of primary care centers and State officials from States of region IV and regional office staff. This group has greatly improved relations between the regional office and primary care centers by creating a greater appreciation on the part of centers of the responsibilities of the regional office while at the same time regional office staff have been made more aware of the day-to-day problems of centers which they oversee. It is our hope that this task force will remain as currently constituted rather than being reorganized as now being proposed.

I would like to close with the following recommendations:

One, there is currently pending legislation which reauthorizes the section 329 and 330 programs. We recommend passage of the amended version of S. 2308 which reauthorizes the health centers as categorical programs for 3 years and repeals the primary care block grant.

Two, the application process is cumbersome and time-consuming and threatens the existance of many viable, well managed centers. We are concerned that the current process places more weight on the ability to write grant applications than on the proven ability to provide quality health services. We recommend a simplified process, especially for established projects which will focus primarily on past performance and continued need.

BEST COPY AVAILABLE

Three, primary care centers and State health agencies are coming to realize that neither is a threat to the other where there is mutual appreciation and respect. We recommend that regional offices be encouraged to build on this emerging positive relationship rather than subverting it as could be the case if the proposed reorganization of the region IV primary care task force is carried out.

Mr. Chairman, Senator Cochran, this ends my formal statement but I would like to comment on one or two items that were brought up before the previous panel.

One has to do with the amount of paperwork that we are faced with from day to day. One of the things that we've noticed is that as far as the Federal Government is concerned, if you are a political subdivision or a State agency, or if you are an institution of higher learning, there is an assumption that everything is A–OK, you can manage everything well and there is very little question as to your competency. In the case of community based programs where you have potential for minority management, where you have minorities serving on boards, making decisions, there's a general feeling of substandard. The requirements placed on community based programs are consistently more cumbersome than they are for programs that are run by State agencies and other agencies that are traditional providers of services. So I wish that you would look closely at the discrimination in requirements that's placed on community based programs versus State agencies and political subdivisions.

On the question of infant mortality, in our State, Senator, the figures are kept for 5-year averages and the latest figures indicate that there was a decline. In Mississippi having the highest rate, the only place it could go was down. What we do see, there's an increase in the number of low birthweight infants that's been documented. And, of course, the implication there is we will be faced further down the road with learning disabilities. In other cases we suspect that the decrease in infant mortality rate probably is going to bottom out and the next 5-year averages will show an increase rather than a decrease.

In response to one other question that had to do with how have we maintained services in the face of a 25-percent reduction in funds and a 29-percent increase in users, this I have to give credit to community based boards, as mentioned by my colleague, Mr. Spees. What happens in the case of community based boards, these boards primarily at the inception of the services, as they establish priorities, what we find is, rather than having the patient suffer, the boards are willing and the staffs of the health centers with their commitment are willing to forego certain things such as rather than buy new equipment and upgrade our facilities, we increase our patient population because more people need it. Rather than seek increases in salaries, cost-of-living increases, our staffs have been willing—as long as they recognize that there are patients who need services, we've been willing to forego salary increases so that we can continue to provide services. The problem is we're about to get to the end of the line. Our facilities are falling in, our equipment

BEST COPY AVAILABLE

is obsolete, and we're losing some of our staff because they can't afford to feed their families on salaries that are 1980 and 1982 salaries.

Thank you again for this opportunity to testify.

Senator COCHRAN. Thank you, Dr. Shirley.

[Audience applauds.]

Senator COCHRAN. I'm glad you're not running against me.

I'm really pleased to have had the opportunity to listen to the testimony that you have presented, on the primary health care centers which you have represented so ably here today. I was looking through some of my notes before this hearing about why we were going to be inviting Senator Weicker to Mississippi to conduct this hearing, and I was recalling instances when we have been contacted for assistance. One of the issues that hasn't really been brought up today was the arrival of funding on time. I can recall in previous meetings where I heard this complaint, and I wonder whether this is a problem that continues or whether it was just an indication of an isolated incident or two. As I understood it, funding would be expected to be received by a certain date and just not arrive, not arrive on time, and many difficulties were caused by that. Is this a problem? Is this a continuing problem? Ms. Ray, do you know whether or not it is?

Ms. RAY. Are you talking about the grant award being received at the beginning of the fiscal year?

Senator COCHRAN. That's correct.

Ms. RAY. I have to say that we've never received ours at the beginning of our fiscal year. We would have telephone confirmation that it was on its way, but normally it's at least 2 weeks after the beginning of our fiscal year that we really had notification in hand that we could spend those funds that had been authorized. We were 2 weeks delayed in limbo. We were still providing services strictly because of telephone confirmation. We really didn't feel comfortable with it. The governing board made a decision to go ahead and do this.

Senator COCHRAN. Well, is that a typical problem that exists around the State with the centers or was that just a problem that you had?

Ms. RAY. I understand that it's——

Senator COCHRAN. Widespread?

Ms. RAY. Yes; that it's not unique with Southeast Mississippi Rural Health.

Dr. SHIRLEY. It has been a critical problem with us. As a matter of fact, I've called your office on several occasions on that particular problem. What happens, we're usually from 1 month to 6 weeks behind. Our funding runs from July 1 and usually, after we receive notification of award, we don't get the funds until 1 month to 6 weeks later.

Senator COCHRAN. I don't see how you can continue to operate. Do you have to go borrow money to pay salaries or what do you do?

Dr. SHIRLEY. That's what we have done. We borrow the money and continue operations, and, as you know, the regs do not allow us to repay interest from the grant, so our staff is, again, willing to have us deduct on a prorated basis the amount of the repayment of the loan that's interest. Actually, our staff pays the interest out of their pockets.

BEST COPY AVAILABLE

Senator COCHRAN. I'm going to ask the Atlanta people to respond. I don't understand that. What's the problem? Is that problem a Washington problem or is it an Atlanta problem, and what can be done?

Mr. WATERHOUSE. First of all, Senator, there has been a——

Senator WEICKER. Would you identify yourself.

Mr. WATERHOUSE. George Waterhouse, Atlanta regional office.

There has been a problem in the past with some applications being awarded late. I think over the last 3 to 4 months we have made a lot of changes in the review process and there have been—the majority of applications now are being awarded prior to the end date of the budget period so that the awards are going out on time.

There have been problems on both sides, though. There have been problems with applications coming in late and that doesn't allow us to complete our review on a timely basis either. And there have been some cases where applications were coming in incomplete. And we've tried to—this is one of the reasons, going back to last year, where we put out a guidance which everybody refers to as the guidance of March 9, 1983, which does tend now, I think, to cause people to put a lot more into their applications in order to be sure that it's complete, and we are looking at streamlining the application process so that we can reduce the paperwork and reduce the time. But we put that guidance out for the task force last year and everybody agreed—the task force and the regional office staff agreed that is what should be in an application and it should cut down on applications coming in incomplete because people didn't know what to send in in an application and it should reduce the number of deferrals. When a project comes in, if it's incomplete or it's later, and there are problems associated with the review, then there is a deferral possibly and you have to resubmit additional material.

So the number of times that we have to go into that process means the applications aren't going to be awarded on time. So it's just a multifaceted problem. And, like I say, in the last 3 to 4 months, the vast majority of applications have been awarded 3 to 4 weeks prior to the end of their budget period. We still have a few that—you know, I think it's much improved. But there are still some coming in late too. We promised the task force that prior to the next meeting—this was the meeting we had in early May—we would produce a draft of a revised document for applications, guidance for application submittal. And we intend—we're committed to reduce the requirements that these applications would have in them so that we can simplify the process, particularly for those projects that are within what they call a project period and are subject to noncompetitive review. I'm hopeful, through what's gone on in the last several months, what we're about into, and which we'll have out in the next few months, will improve the process significantly.

Senator COCHRAN. I hope that we can cut down on the burden, particularly for these centers that are unable because of limited resources to have staff who are capable of dealing with these things, you know, in

BEST COPY AVAILABLE

a professional grantsmanship kind of way. Are they going to be penalized? Let me just ask you that. The small centers with somebody that really is not a professional grant application filler-outer, how are they going to deal with this competition? How are they going to get funded?

Mr. WATERHOUSE. Well, the projects that come in under continuing review and the new applications are subject to the department's grants administration requirements for objective review, which the intent is to avoid conflict of interest situations. But the objective review process represents a recommendation to the regional health administrator, and a recommendation only. The regional health administrator has the final authority on the grants that are approved, and the branch—in this case the branch that I represent, which is the primary care branch which administers these programs—does get to see and review the recommendations made by the objective review committee, and we have an opportunity to present a case to Dr. Wright the same as the objective review committee does, give him a recommendation, if we feel that decision is inappropriate or is based on something which is not accurate. The objective review criteria, though, in the review process, does require the committee to review the contents of the application. So there's potentially some problems there, but I think we've not had those problems. We have, in several instances, had to make recommendation to Dr. Wright, the regional health administrator, on a position which is different than the committee's recommendation, but I think we have been able to prevent some kind of catastrophic situation happening where a grant has not been recommended when it should be recommended. The committees basically, though, are on the side of the grantee in terms of recognizing, I think, that they're not all grantsmanship experts in that case.

I think the other thing is that the centers do have administrative staff. It's not that it's—I recognize Dr. Shirley is also a clinician and project director, but the vast majority of the centers are administered by administrative staff, so the clinical staff, in a sense, are not taking time away from seeing patients to develop these applications. And I recognize that all centers have different levels of administrative staff. Some have a lot more resources than others and we should attempt to gear our requirements to those. The fortunate thing, in a sense, is that the regulations require all centers to meet the same requirements whether they are small or large.

Senator WEICKER. I just want to follow up on one question, though. Have there been funding cuts that have resulted in a reduction in your own staff in Atlanta?

Mr. WATERHOUSE. The reductions were in 1981 when most of the block grant legislation was enacted. We have not had direct cuts in the primary care branch, though. Most of the cuts were in other branches of health services.

Senator WEICKER. In other words, you would not attribute any delays to a reduction in your own staff.

BEST COPY AVAILABLE

Mr. WATERHOUSE. We have had reductions in support staff, which we had problems in terms of getting support staff for a while, but the professional staff is about the same level as we had before.

Senator COCHRAN. I just hope that we can convince the people that are running the program in Washington and in Atlanta, too, that we can't expect these centers to have a whole staff of lawyers and CPA's and M.B.A. graduates, you know, to fill out these complex forms. I hope that it can be simplified. I'm encouraged with your statement that there's an effort being made to streamline and simplify. That could be a very big help.

Senator WEICKER. You know, one of my other duties is that I chair the Small Business Committee. A year ago we got legislation passed that, in effect, had the Government pay interest when it didn't pay its bills to small business people. I think maybe a way to cure this situation is from now on let the delayor go ahead and pay the interest on the money that's borrowed, whether that happens to be at the local level if the application wasn't filed on time, or Atlanta if you fellows don't produce the money on time. It seems to me to be the only fair thing to do.

Senator COCHRAN. This would be a good amendment to offer to your bill.

Senator WEICKER. If I could just very briefly—first of all, I'm glad, Doctor, you raised the point of low birthweight babies. I meant to include that in my opening remarks. Indeed, that is the testimony that we're getting from throughout the United States. And, as you say, the cost there is going to come in the out-years, just as the cost of your not getting the equipment you need is going to be paid in the out-years. So all of this budget cutting is fine. We achieved something this year. But what is it going to do to the budgets 10 and 15 years from now? I'll tell you: You won't have saved anything. You, as a doctor, I think know that better than anybody else. You'll be paying enormous amounts of money that need not have been expended, and the low birthweight problem is certainly one that has every indication of that.

Now, one last question that I have of this group. I meant to raise it with the group before you and your colleagues. I have received testimony in Washington that for all you're doing and that for all our medical delivery systems—medicare and medicaid—does, there are 28 million people in this country who are not served at all, not served at all. And I'm wondering if you see that here in Mississippi. Do you have a percentage of these people that get nothing? Would you like to comment on that?

Dr. SHIRLEY. There are a number of counties that fit all the criteria of being medically underserved, and in those counties the people who need health care, if they are unable to make it to one of the charity hospitals, which are spread pretty far apart, or to the medical center here in Jackson, they don't receive service. They just don't get it.

Senator WEICKER. Have you had many of your hospitals go private, if you will—or for profit, I guess, is a better term to use—thus compound-

BEST COPY AVAILABLE

ing this problem? And many of them when they do go for profit, that is, privately owned or owned from the point of view of stock ownership, if you will, then they seem to eschew those patients that don't produce profit for them. And, of course, these are all people, probably, that you serve. Does that compound the problem of putting a greater weight on the few hospitals that are left?

Dr. SHIRLEY. It certainly does. To give you an example, it goes a little beyond that. Hospitals who have physicians who are trying to live up to their creed of serving the poor, the nonpoor, and everybody, there is increasing pressure on the physicians. Those physicians who admit a high percentage of medicaid persons, for instance, are pressured in one way or another to limit their admission of those patients, because the hospitals claim that they lose money on medicaid patients. And hospitals which were built with Hill-Burton dollars and have an obligation to provide a certain percentage of indigent care, they're writing—they're satisfying their indigent care provisions by using bad debts as free care.

Senator WEICKER. By using—would you explain that.

Dr. SHIRLEY. They report—as part of the indigent care, they use uncollected funds from nonindigent patients and they write that off.

Senator WEICKER. Nonindigent patients.

Dr. SHIRLEY. Right. And they write that off as indigent care, and that's how they satisfy their requirements. But more critical is almost—well, all of our—the Mississippi Medical and Surgical Association, which I chair its board, our physicians throughout the State are being harassed because they insist on admitting medicaid patients and they insist on admitting other patients who have no source of pay. So the hospital administrators are putting pressure on us to limit our admission of those patients.

Senator COCHRAN. Dr. Shirley, thank you for being here.

Senator WEICKER. Thank you very much.

Senator COCHRAN. Ms. Ray, thank you for an excellent presentation.

HOME HEALTH ASSOCIATIONS AND AGENCIES PANEL

STATEMENTS OF:

ELAINE BURCHFIELD, PRESIDENT, MISSISSIPPI HOME HEALTH ASSOCIATION

DONALD W. BAXTER, PRESIDENT, SOUTH MISSISSIPPI HOME HEALTH AND REHABILITATION AGENCY

MARILYN WILLIAMS, MISSISSIPPI HOSPITAL ASSOCIATION

Senator COCHRAN. Our last panel of witnesses are representatives of the home health associations and agencies. We have Ms. Elaine Burchfield from Kosciusko who is president of the Mississippi Home Health Association. Ms. Burchfield, if you will come forward. And Mr. Don Baxter who is president of the South Mississippi Home Health and Rehabilitation Agency in Hattiesburg, and Ms. Marilyn Williams of the Mississippi Hospital Association. We appreciate so much your patience, first of all, and your presence.

BEST COPY AVAILABLE

We invite you to go ahead with your testimony. We have statements which we thank you for, and ask you to make summary comments from them so we will have an opportunity for discussion.

STATEMENT OF ELAINE BURCHFIELD

Ms. BURCHFIELD. Senator, again, I'm Elaine Burchfield, president of the Mississippi Home Health Association. As you have commented, we do have a little volume here that we feel includes the major points that we would like to see addressed and like to see some interest in. I would, if you would bear with me at this time, like to turn the testimony over to Mr. Baxter because he is a member of the board of directors of the National Association of Home Care and there are some items in here that I think he has more information on. I would be happy to let the testimony come back to me. There are some issues as a nurse that I would like to just briefly go over. I will not read this word-for-word, I promise you.

Senator COCHRAN. Good. Thank you for taking the time, though, to provide this to the committee. It is going to be very helpful to us.

Don, you can proceed then with your testimony.

STATEMENT OF DONALD BAXTER

Mr. BAXTER. I sure will. Welcome to Mississippi, Senator Weicker. We appreciate you having Senator Cochran down here so we can talk with him.

Senator Cochran, I would like to take a moment to thank you for your work on behalf of the elderly and families of America and sponsoring or cosponsoring the bill on intermittent care, the National Home Health Week, the Home and Community Based Service Act for the Elderly, the Community Home Health Services Act. All of this shows us that you are acutely interested in the family units in Mississippi and the elderly. That is a business we're also involved in in providing services directly to those people.

Home health, which has been around for several decades now, was made available as a medicare benefit in 1967–68. I think Congress showed a great deal of wisdom at that time in saying if we can take a medical resource and prevent institutionalization by sending these medical resources into people's homes, we will better serve the citizens. I think that was a tremendous idea. Over the years it has developed into a vital, viable link in the health care delivery system. There have been a few changes recently that have those of us who are in the industry extremely concerned. With the advent of DRG's, there seems to have been something that really shook up the boat as far as what was covered and what was not covered under home health care. It started a great deal of scrutiny by the national association on exactly what was going on across the country, and there are a few things that we are confounded as to what their purposes are.

Initially, in the State of Mississippi and across the Nation, when the home health benefit was made available, we found that existing nursing

BEST COPY AVAILABLE

associations, private not-for-profit charitable organizations, were the ones that took the extreme risk by coming into the industry and building the industry that exists today. In the State of Mississippi, there was not a single patient in the year 1982 or 1983 who was referred for home health services and who was otherwise qualified who did not receive home health services. Now, it is nice to have planners and looking ahead to see what is going on, but when you've got the actual data in front of you and you're faced with short dollars on the cost reimbursement system and start trying to add new providers to participate in that on a cost reimbursement bases, you're only going to drive the costs up. I'd like to refer back to what Senator Weicker said about do we find that there is a proliferation in the number of charitable hospitals that are now going for profit, so to speak. The home health industry across this Nation is caught up head and toes in that particular proposition right now. As a matter of fact, in Mississippi, I understand that at the next health care commission meeting, there are going to be several agencies who are going to try to go proprietary. And one of the reasons this is is that the traditional people who have served home health patients across the country are seeing under this procompetition mode that we're in, they're seeing that the Government cannot visualize what the industry is about; that if you have organizations that are being based on a cost basis and you say let's get more competition regardless of whether or not we're meeting all the service requirements, that adding additional agencies can only drive costs up. And here is a key word and I think this is going to be a word that you'll hear a lot of in the next couple of years at the Capitol—vertical integration. That is back to the reason for going proprietary. There is an advantage now for new people who are coming into the industry, especially if we allow those who can capture the referral sources to be the new entry, the traditional services will dry up at the bottom. For instance, if a doctor's clinic who has been referring to the State health department, maybe the local hospital, maybe VNA, private agencies—if the doctor's clinic gets their own agency, they will end up referring all their patients to that particular agency. All the other agencies will die. This does not mean that cost is going to be contained. As a matter of fact, in some of the northeastern States where this is more predominant than it is in Mississippi at this time, we are finding the costs are escalating in the home health industry at a very rapid rate.

One other thing I would like to just drop off and mention because it's a primary part of my testimony, one of the big problems we have is getting accurate statistics. Most of the ones we see have been refuted one way or the other and nobody seems to want to sign their name on any statistics that they come up with, whether self-generated or gotten from another source. The interpretation of the regulations at the various HCFA regions—there's 10 of those and there's approximately 58 intermediaries in the United States—vary dramatically on what is covered for a home health patient who is otherwise eligible under medicare. In Mississippi, for instance, I am in direct competition with 80 other home

BEST COPY AVAILABLE

health agencies, all of which can provide a basic item called Linsine which is to protect the patient from undue moisture on the skin and help keep the bed dry. These 80 people that I compete with, their intermediary says to then, "It's fine. We pay for this particular item." If the intermediary I use tells me that I cannot supply that item, what that means is a doctor, when I say, "Hey, I'm sorry. I can't use this," he says, "Well, I'm looking for a home health agency that can meet the needs of my patients. Therefore, you will no longer be in consideration for my referral." It happened exactly that way. It happens in dozens of areas every day, and we cannot seem to intervene in the proposition of all HCFA regions and intermediaries interpreting the regulations the same way. I think that if we hand HCFA the money, HCFA takes the rules and regulations and trains all the regions in those exact regulations, and those people contract with FI's, I think that pressure can be brought to bear to get performance under these particular contracts whereby recipients of medicare benefits in various parts of this country are not discriminated against.

Thank you.

Senator COCHRAN. Thank you very much, Mr. Baxter.

We appreciate Marilyn Williams being here representing the Mississippi Hospital Association today. You may proceed.

STATEMENT OF MARILYN WILLIAMS

Ms. WILLIAMS. Thank you, Senator Cochran and Senator Weicker. It's a pleasure to be here today to represent 121 member hospitals, including 22 who do provide home health care services either through their own agencies or through contractual arrangement.

Prior to speaking on home health care, I was wondering if you all would permit me to make a couple of comments on earlier subjects that came up. I've heard y'all's concern on perinatal care, particularly prenatal care, and that is something that we have been very concerned about in Mississippi, particularly providing care to those members of intact families. And there is a piece of legislation that is being considered by Congress which we think would be very beneficial to Mississippi, the Cranston bill, or the Waxman bill in the House, which would basically expand medicaid coverage to more married females.

In addition, as, Senator Cochran, you may be aware, we have passed in Mississippi a limited medically needy program which these additional funds would be available for, but, unfortunately, due to the cutbacks in medicaid funds in the State of Mississippi, there has not been enough money to implement that program.

In looking at that area, there has been remarks about the role of hospitals in providing delivery services. I think it may be of interest to you all that approximately 25 percent of all deliveries in Mississippi presently are medicaid. That compares to approximately 10 percent of all patients in Mississippi being medicaid. In addition, there is some 15 to 20 percent that falls into the charity and bad debt categories.

BEST COPY AVAILABLE

There has been some mention of utilizing bad debts as Hill-Burton, which I'm not positive is going on because I don't think it really is possible under the Federal regulations. But the truth of the matter is in Mississippi, a lot of that bad debt, if you look at the socioeconomic class of our people, is indeed indigent care. It's not people who did not pay because they did not want to.

Senator WEICKER. I believe the doctor's comments specifically referred to the nonindigent bad debts.

Ms. WILLIAMS. I guess what I'm trying to——

Senator WEICKER. The other question I would raise to you is: If, indeed, your testimony is correct that 25 percent are medicaid—and there we're taking about deliveries; right?

Ms. WILLIAMS. Right.

Senator WEICKER [continuing]. And if the hospitals are discouraging medicaid patients, where does that leave everybody?

Ms. WILLIAMS. Well, I will not say that hospitals at times may not be discouraging extended hospitalization of medicaid patients, because I think the hospitals more and more are becoming concerned financially of staying open and staying in business, and if a patient does not really need to be there, which pierces the role of home health, is discharging that patient as soon as possible.

On the other hand, I do know from a survey that we have done for the past 2 years, that 25 percent of all the deliveries in Mississippi are, indeed, medicaid patients, and that hospitals are, indeed, providing that care. We, in fact, do find a lot of times hospitals are criticized for not taking medicaid patients and a lot of times it's the medical staff themselves who refuse to take medicaid patients. And, as you all know, hospitals do not admit patients; physicians do. And I know that that is particularly a problem in some areas of the State.

Senator WEICKER. Is that the same as between—what do you call it—the proprietary hospitals, the ones that are investor owned, and the other hospitals that wouldn't be there?

Ms. WILLIAMS. There really isn't. A private practitioner, whether he or she is on the staff of a county-owned facility or a for-profit facility or a not-for-profit private facility, chooses who they will take care of and who they won't accept. We find that in some of our—we don't find much difference, actually, between the amount of indigent/medicaid load, whether it's for profit or not for profit. On the other hand, while we're seeing some management contracts come in from proprietary firms, we're not really seeing that much takeover because there is a State law in Mississippi prohibiting the selling of a county-owned facility to a for-profit company, and that is one of the reasons in Mississippi that we're not seeing perhaps what is being seen in some other parts of the country in that regard.

Senator WEICKER. That sounds like good news. I hadn't heard about that.

Ms. WILLIAMS. That law has been on the books for many years; I don't know exactly how long.

BEST COPY AVAILABLE

But the point that I was trying to make is that hospitals do play a major role in providing prenatal care—not prenatal care but perinatal care through delivery services to indigent patients and to others. But it is a load that is quite significant because of the impact on cost shifting. And with expanded coverage such as a limited medically needy program or the Cranston-Waxman bill, that would alleviate some of the need for services in the area.

Also, when we find patients showing up with no prenatal care, it makes for more expensive costs, and particularly in these small rural hospitals. They don't have the capability of providing that care. I know there was a mention earlier of a particular small hospital not being able to deliver that many patients. Part of that problem is they just don't have the capability of providing high risk care, and those women do need to be moved on to another hospital.

Getting back to the subject of home health care, the Mississippi Hospital Association, which was established in 1981, was established for the purpose to enhance the health and well-being of the people of the State of Mississippi by assisting hospitals to provide the highest quality of appropriate health care at an optimum cost.

PREPARED STATEMENTS

Senator COCHRAN. Thank you for your testimony. We will include your submitted statement in the record at this point along with that of Donald Baxter.

[The statements follow:]

BEST COPY AVAILABLE

Statement of Marilyn Williams

I am Marilyn Williams, Vice President for Planning, Regulation, and Data for the Mississippi Hospital Association (MHA). I appreciate the opportunity to speak to you on the topic of home health care on behalf of our 121 member hospitals including 22 which provide home health care services, either through their own agencies or by contractural agreement with a hospital-based agency.

The purpose of the Association, which was established in 1931, is to "enhance the health and well-being of the people of the State of Mississippi by assisting hospitals to provide the highest quality of appropriate health care at an optimum cost."

Consistent with that purpose has been the Association's support over the years for the development and funding of home health care services. In fact, nationwide, there is a long history of involvement by hospitals with home health care services. An early example of this involvement was a plan devised in 1796 by the Boston Dispensary for sending physicians-in-training and nurses into the homes of the sick and poor.[1]

During the past several years MHA has encouraged hospitals to develop their own home health care agencies, or to facilitate and involve themselves in the development of home health care services by another community agency. Historical reasons still valid today for our support for the development of hospital-based home health care services are:

1. Continuity of care is enhanced because there is a smooth transition from inpatient to home care by giving hospitals control over the post-discharge care of their patients.
2. Physicians can maintain involvement with a hospital-based program through involvement with the hospital medical staff, thereby assuring quality and appropriateness of the services provided.
3. Hospital-based home health care programs enable the hospital, and the patient and his/her family to begin planning for post-discharge care from the time of hospital admission, including the acquisition and placement of equipment and the scheduling of personnel, well before the patient leaves.
4. Home health care programs can be developed within a hospital with a nominal in hospital overhead because of the availability of staff and back-up services such as laundry, radiology, and other technical facilities. Also, the hospital adding home health care services needs little additional administrative staff since the hospital's controller and billing department can be used for the home health care program, as well as for other hospital services. Also, supplies many times can be obtained less expensively through the hospital because of volume discounts and group purchasing program.
5. In FY 1982 the average cost per visit for hospital-based home health care agencies in Mississippi was approximately the same as that for private, non-profit agencies reimbursed through Blue Cross. The average cost per visit for the State Board of Health and that of the agency reimbursed directly from the Health Care Financing Administration (HCFA) exceeds other agencies in the state. However, the average cost per

BEST COPY AVAILABLE

patient for hospital-based agencies of $652 for FY 1982 was much less than the $1056 for private non-profit agencies reimbursed by the local fiscal intermediary, or the $3863 reimbursed from the Office of Direct Reimbursement (ODR). (Data is attached.)

6. The availability of home health care services reduces the patient's hospital length of stay and thereby hospital costs. In addition to being a possible means of controlling the escalating cost of care, home health care is a socially responsible method of permitting people to keep their own life styles by returning or remaining in their homes.

In addition to the above reasons, there are new enviromental elements which makes the development of hospital-based home health care agencies beneficial to hospitals and their communities. These elements are:

1. Although the elderly has made up a disproportionate number of hospital patients for some years, with an increasingly older population there is a corresponding increase in the number of elderly hospital patients. Many of these patients when no longer in need of acute care are still in need of some nursing care and other health care services. The development of home health care services enables hospitals to meet the needs of these patients.
2. As a result of an ever increasingly older population and their need for health and health-related services, hospitals are developing and expanding services to the elderly such as swing beds and "LifeLines" to home patients. Under "LifeLine" programs, the patient is given either a special telephone number or a "beeper" device that she or he can use in the case of an emergency. Home health care services are an essential component of a continuum of care for the elderly.
3. In Mississippi we have less nursing home beds than that needed. For example, in a one-week period in December of 1983 a survey showed that 299 hospital patients were awaiting nursing home placement. However, at this time additional nursing home beds cannot be constructed due to a legislative-mandated certificate of need moratorium for nursing home beds. Some of those persons awaiting nursing home placement can be maintained at home at least temporarily with the utilization of home health care services. Thus, the need for home health care services is intensified.
4. The enactment of the new DRG-based Medicare prospective payment system has intensified the need for home health care services since the new system provides an incentive for early hospital discharge.
5. A home health care program can be a vehicle for providing hospice care to terminally ill patients in their own homes. In fact, home health care services is a required component of care for hospice programs (federally-certified) under the Medicare program.
6. Many small, rural hospitals are discovering that they must diversify by providing other health care services, such as home health care, if they are to remain financially viable institutions. It is desirable that small, rural hospitals continue to be financially viable because of the need for emergency and primary health care services in rural areas. In addition, small, rural hospitals are an essential mainstay of the economy of rural areas. For example, Mississippi hospitals --

BEST COPY AVAILABLE

the majority of which are small and rural--employ 37,000 people and contribute $700,000,000 to the state's economy.

Although there are many benefits of hospital-based home health care agencies, hospitals in Mississippi presently cannot begin home health care programs because of a certificate of need moratorium recently extended by the legislature. In addition, there are stringent restrictions on the establishment of contractual arrangements between hospitals and existing agencies. Since these are state issues, however, we do not wish to go into detail at this hearing.

Insofar as federal activity in the area of home health care, the Mississippi Hospital Association believes that in general the requiremnts for reimbursement for home health care services, etc., are equitable and fair, and do not discriminate in favor of one type of home health care provider. Also, the Mississippi Hospital Association would urge Congress, including the members of this committee, to continue exploring ways to expand reimbursement for home health care services. We do, however, understand the problems the Congress faces in expanding funding for this most worthwhile program in light of the existing deficit in the federal budget. In addition, we would not like to see a reduction in the funding of other health care services including that of acute hospital care as a result of added funding for home health care.

In addition, it is my understanding that not all of the regional offices or even fiscal intermediaries interpret the federal requirements for home health care eligibility and reimbursement the same. Without commenting or knowing fully whether the more stringent or more flexible interpretation is desirable, we do urge that the interpretation be consistent from one region to another or from one fiscal intermediary to other.

In this regard, we believe that the new requirement for all home health care agencies to be reimbursed through a local fiscal intermediary and not the Office of Direct Reimbursement is desirable.

That concludes my remarks, but I would be glad to attempt to answer any questions you may have.

Thank you for the opportunity to express our view.

[1]Evelyn McNamara, ACSW, "Home Care--Hospitals Rediscover Comprehensive Home Health", Hospitals, November 1982, Pages 60-66.

NOTE

This data was compliled from the most current Medicare cost reports available as of June, 1983. In light of this some of the data is from unaudited cost reports. While subsequent to audit there will be some variation in the figures from agency to agency, there should not be significant variations in the data when the agencies are viewed as a whole or in groupings.

BEST COPY AVAILABLE

BEST COPY AVAILABLE

PRIVATE NON-PROFIT HOME HEALTH AGENCIES

Medicare Costs	Number of Medicare Patients	Total Visits	Medicare Visits	% Medicare Utilization	Medicare Average Cost/Patient	Medicare Average Visits/Patient	Medicare Average Cost/Visit
432,459	95	8,085	7,937	98	4,552	84	54.49
491,470	233	17,651	17,214	98	2,109	74	28.55
148,966	58	2,427	2,427	100	2,568	42	61.38
184,426	80	3,951	3,635	92	2,305	49	50.74
412,995	271	15,431	14,722	95	1,524	54	28.05
309,721	137	4,984	4,839	97	2,260	35	64.01
631,281	492	27,224	26,075	96	1,283	53	24.21
624,018	369	12,519	12,017	96	1,691	33	51.92
180,820	134	5,960	5,737	96	1,349	43	31.52
708,812	515	15,884	15,884	100	1,376	31	44.62
365,472	300	13,254	12,770	96	1,218	43	28.62
207,759	154	6,685	6,010	90	1,349	39	34.57
324,007	217	8,850	6,974	78	1,493	32	46.46
274,905	268	10,892	10,753	99	1,025	40	25.57
240,222	262	11,470	11,252	98	916	43	21.35
228,175	418	9,382	8,964	95	1,116	22	25.45
222,236	186	1,357	1,357	100	1,195	7	163.77
480,423	510	13,887	13,256	96	942	27	34.62
187,338	194	6,227	5,598	90	965	29	33.47
295,715	389	14,212	13,751	96	760	35	21.50
159,670	261	8,544	8,468	99	612	32	18.86
111,065	374	7,593	7,593	100	832	20	40.97
698,879	819	16,772	13,234	95	853	17	52.81
30,462	51	493	493	100	597	10	61.79
544,135	1,226	14,222	14,202	99	444	12	38.31
9,037	22	165	165	100	410	8	54.77
137,381	336	2,208	2,208	100	409	7	62.22
,841,885	8,371		248,156				

BEST COPY AVAILABLE

HOSPITAL BASED HOME HEALTH AGENCIES

Medicare Costs	Number of Medicare Patients	Total Visits	Medicare Visits	% Medicare Utilization	Medicare Average Cost/Patient	Medicare Average Visits/Patient	Medicare Average Cost/Visit
368,881	134	15,318	14,797	96	2,752	110	24.93
166,237	153	6,855	6,643	97	1,086	43	25.02
67,406	57	2,073	1,991	96	1,181	35	33.82
168,406	293	6,651	6,498	96	1,456	25	57.58
403,141	392	11,958	11,958	100	1,028	30	33.71
127,621	142	4,126	4,126	100	899	29	30.93
458,159	469	10,757	10,541	98	968	22	43.09
184,156	188	1,576	1,510	96	980	8	121.95
176,510	217	3,757	3,730	99	813	17	47.32
394,097	466	4,486	4,299	96	856	9	91.67
294,200	346	2,028	2,028	100	850	6	145.07
131,813	269	3,087	3,087	100	490	11	42.70
88,562	157	1,623	1,491	92	564	9	59.40
63,292	173	2,605	2,387	92	366	14	26.52
200,868	802	5,167	5,167	100	250	6	38.95
197,847	1,169	2,706	2,657	98	169	2	74.46
66,367	365	2,598	1,969	75	182	5	33.71
3,753,479	5,752		84,769				

SBOH HOME HEALTH AGENCIES

Medicare Costs	Number of Medicare Patients	Total Visits	Medicare Visits	% Medicare Utilization	Medicare Average Cost/Patient	Medicare Average Visit/Patient	Medicare Average Cost/Visit
5,895,072	1526	143,781	113,330	78	3863	74	52.02

Letter From Donald W. Baxter

May 17, 1984

Senator Lowell Weicker, Jr., Chairman
Labor-HHS-Education Appropriations Subcommittee
United States Senate Committee on Appropriations

RE: Testimony for the 05/21/84 Hearing in Jackson, Mississippi

Dear Senator Weicker & Subcommittee Members:

Enclosed is written testimony which I wish to enter, along with this letter, into the record of your hearing scheduled for May 21, 1984, in Jackson, Mississippi. I believe the Subcommittee on Labor-HHS-Education Appropriations is in a unique position to investigate the root causes of the problems outlined in this document; and I appreciate the opportunity to appear before your subcommittee and to present this written material.

Home health is a vital and cost-effective component of the healthcare delivery system in this country and its growth in size and effectiveness has proven the wisdom of the Congressional foresight which established this benefit in the 1960s. Home care is not always appropriate for everyone. But when it is, home health allows the health care needs of our citizens to be met in the comfort and privacy of their own homes, where they reap the intangible--albeit very real--benefits of familiar surroundings and the warmth, concern, and close proximity of family and friends. No one in the medical community would dispute the fact that one's attitude and mental state have a great impact upon one's physical health. Being able to remain in one's own home, while still being able to have one's healthcare needs met, can be of incalculable emotional--and thus physical--benefit. The patient, however, is not the only beneficiary in home care. The utilization of home health care whenever appropriate also benefits the American taxpayer, for home health has proven to be much less costly than institutional care and is often much more satisfactory. It is cost-effective.

Since its inception in the 1960s, the home health industry has grown and expanded to meet the healthcare needs of many Americans. Yet there are still some deficiencies. We could--and should--be doing more. The industry has no problem with the Congressional intent behind the home health benefit--our problem lies with what we in the home health industry perceive to be the subsequent circumvention of this intent. Varying interpretations of the home health regulations have taken place through the years, perpetrated by the Health Care Financing Administration (HCFA), its 10 Regional Offices, and the various fiscal intermediaries it employs. We find many of their applications and interpretations to be arbitrary, capricious, and totally inconsistent. This leads to inequities in the treatment of beneficiaries and jeopardizes the entire concept of home health. The home health industry is providing a valuable, much-needed service to the citizens of this country. When reimbursement is applied inconsistently and in a manner which the provider has not been led to expect, his business--his SERVICE to the population--is placed at extreme risk. The ultimate losers are the beneficiaries--they lose the care they need to remain at home--but the taxpayer loses as well. His money is wasted in paperwork battles and in paying for the institutionalization of those people no longer able to take advantage of home care.

The issues I am addressing here are by no means all of the matters currently concerning the home health industry, nor are these addressed as fully as I would like. Time and personnel limited what I was able to compile, however I believe you will be able to get a reasonable clear idea of the issues, our concerns, and the reasons for these concerns. If you have any questions or desire further clarification of specific matters, I will be happy to assist you. Let me also recommend that you utilize the knowledge and expertise of the staff of the National Association for Home Care. They have the resources to provide you with extensive documentation on all issues affecting home health care.

I'd like to take this opportunity to point out that many of the issues I'm addressing overlap and intermingle. One problem you will note running throughout this testimony is not addressed specifically, yet is of prime concern to all home health providers--that is, the varying interpretations of Medicare regulations and guide-

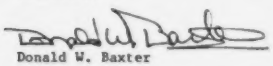
BEST COPY AVAILABLE

lines. These variances occur between HCFA and its Regional Offices, between Regional Offices, and among various fiscal intermediaries (FIs)--sometimes even among FIs within the same HCFA Region. Since I, personally, am most familiar with Region IV, my oral testimony will focus on relating the attached issues to my experiences with them. Please keep in mind, however, that these issues are of nationwide concern and not by any means limited to a particular provider, Region, or FI. The problems are universal--its only the applications that vary. And that, as I have pointed out, is a serious problem in and of itself. And one which we expect the elimination of the Office of Direct Reimbursement (ODR) to only exacerbate. I beg you to keep this in mind as you study each of the issues.

I wish to make clear that my testimony is my own. While I have solicited input from other Region IV home health providers and from the National Association for Home Care, where I am a member of the Board of Directors, I personally bear full responsibility for the delineation of these issues and the positions taken.

Again, thank you for the opportunity to testify before your subcommittee. I consider this a great honor and hope you will find my input to be of assistance.

Sincerely,



Donald W. Baxter
Presidnet
SOUTH MISSISSIPPI HOME HEALTH AND
REHABILITATION AGENCY, INC.

Region IV Representative
Board of Directors
NATIONAL ASSOCIATION FOR HOME CARE

HHS/HCFA CIRCUMVENTION OF THE REGULATORY PROCESS

ISSUE: Over the past two years HHS/HCFA have undertaken a number of regulatory actions which circumvent and violate the regulatory process as required by the Federal Administrative Procedures Act (APA), the Reduction of Paperwork Act of 1980 (45 U.S.C. 3501), Executive Order 12291, and the Regulatory Flexibility Act (5 U.S.C. 605b). In many situations, HCFA has issued guidelines in its manuals (HIM-11, HIM-13, and HIM-15) or written or verbal policy directives making changes of substance which should be published for comment in the Federal Register (under the APA) and which have either a form necessary for approval by OMB or an impact on small business (which the Paperwork Reduction and Regulatory Flexibility Acts required be published in the Federal Register). This has occurred most recently with HIM-11 draft or actual guidelines on "intermittent care," "homebound," and "skilled nursing" issues; HIM-13 draft revision on documentation requirements; and policy directives on IV therapy, hyperalimentation, and kidney dialysis.

NOTE: If fact, almost every issue addressed in this entire document can be taken as an example of this circumvention.

Even when HCFA does use the Federal Register procedure, it still often does not adhere to the Regulatory Flexibility Act requirement of including an analysis of the proposed rule's impact on small business and often publishes regulations in "interim final" (?!) form, thus impeding the opportunity for public comment. This recently occurred in the issuance of the following regulations: October 26, 1982, physicians on boards; December 6, 1982, interest charges on overpayments/underpayments; December 30, 1982; access to subcontractors books and records; and August 2, 1983, phase out of ODR (these are just a few examples). In fact, when questioned as to why HCFA has not prepared the required regulatory impact analysis, HCFA replied that an impact statement would be completed before ODR was eliminated. Representative Marty Russo (D-IL) blasted HCFA by saying that it is absurd to prepare an impact statement after deciding to dismantle ODR. Congressman Russo stated he would "hardly expect [HCFA] to come up with anything now that would deter the elimination of ODR. [HCFA] should implement the law as written, not as is advantageous to your needs." (Other examples follow below.)

POSITION ON THE ISSUE: HHS/HCFA must not be allowed to use written or verbal policy directives and manual issuances to accomplish substantive changes in the Medicare program. HHS/HCFA must not be allowed to promulgate regulations which do not include the projected impact on small business.

BEST COPY AVAILABLE

RATIONALE:

Such actions violate the Administrative Procedures Act, the Regulatory Flexibility Act, the Paperwork Reduction Act of 1980, and Executive Order 12291.

OTHER SELECTED EXAMPLES OF CIRCUMVENTION:

The APA requires that when "substantive changes" are made, proposed regulations must be filed in the Federal Register, the public must have the right to comment, these comments must be evaluated by the Department and final rules promulgated which have a rational basis in the record and which are in the best interests of the Medicare program. Instead, HCFA and HHS have been arbitrary and unlawful in issuing new Medicare "guidelines" and then enforcing these guidelines as if they were law and regulation.

In January, 1984, NAHC reported that HCFA has behaved in the most blatant manner thus far, not only nullifying the procedural rights of providers, but also nullifying the legal and constitutional rights of Medicare patients to an effective appeal when an intermediary decides not to pay their Medicare bill. The problem is created by a new provision issued by HCFA, revising Section 255-257 of HIM-11, the Manual which contains guidelines for intermediaries to follow in paying Medicare claims. This is a different document than the Code of Federal Regulations in that the regulations further spell out what Congress had in mind when they passed the Medicare Act and regulations are enforced as law of the land.

The new provision says that when they are confronted with a Medicare claim denial, Medicare beneficiaries may not designate employees of a home health agency as their legal representative for purposes of appealing such claims. Significantly, the guidelines do not exclude nursing home employees, or social workers, or hospital employees from playing this role--just employees of home health agencies. These new guidelines were given an effective date of 01/18/84. The new guidelines were not published in the Federal Register, there was no opportunity for comment, no prior consultation with the National Association for Home Care, and no notice of any kind to beneficiaries or providers.

The existing HIM-11 provision does not address the issue of beneficiary designation of an HHA employee as his/her representative. However, current regulations (42 C.F.R. 404.1701) specifically state that beneficiaries whose claims are denied are allowed to designate an employee of the HHA as the beneficiary's representative for purposes of making an appeal. In such situations, the designation must be in writing, signed by the beneficiary and the representative and filed along with the appeal.

HCFA's actions can be challenged on several legal grounds:

The change is a matter of substance which affects the rights of beneficiaries and providers and should be issued only through the rulemaking procedure required under the Administrative Procedure Act (APA).

Circumvention of the APA eliminates a small business impact analysis (required under the Regulatory Flexibility Act of 1980) in a situation where the change clearly impacts HHAs, particularly small ones.

The guideline directly contradicts an existing regulation (42 C.F.R. 404.1701) which was promulgated following the APA procedure.

The guideline violates the equal protection clause of the U.S. Constitution by singling out HHA employees and denying them the ability to act as designees of the beneficiary. Employees of hospitals, nursing homes, and other providers still retain the right of designation.

LIBERALIZATION OF "INTERMITTENT CARE" DEFINITION

ISSUE: In order to qualify for Medicare home care benefits, a patient must be in need of "intermittent" as opposed to daily, 24-hour-a-day care. The present guidelines allow for daily visits for a maximum of three weeks. Thereafter, visits may be continued upon a showing of exceptional circumstances. Moreover, the guidelines have permitted more than one visit to the same patient on the same day, perhaps one visit from a nurse and another from an aide, depending upon a showing of need. Information collected from a number of States indicates that various restrictive interpretations of the term "intermittent" are being imposed by some intermediaries. In some instances, it has been used to bar more than one visit to an individual a day regardless of the justification. In other instances, clients who are in need of and who receive services 5, or even 3, days a week are being deemed as in need of daily care and therefore not compensable. There are even reports that such determinations made in the

BEST COPY AVAILABLE

present based upon restrictive interpretations are being applied retroactively, resulting in retroactive denials.

The irony is that hospitals are discharging more clients who are in need of intensive nursing, physical therapy, and other services into the hands of home care agencies, who are now being told that they cannot care for them because they need more than intermittent care. With the hospital prospective payment plan now in effect, the problem is likely to be exacerbated, with patients being released from hospitals more quickly and in a sicker condition. The further irony is that government policy is pushing many clients into institutional settings when they prefer to stay at home--with resulting increased costs to the government.

Definitions of what constitutes "intermittent care" vary tremendously, depending upon the fiscal intermediary's interpretation. As a result, what is supposed to be a national program is not enforced uniformly and what is covered for one beneficiary in one state is not covered in another state.

Several pieces of legislation have been introduced to clarify and liberalize the "intermittent care" definition. Congressman Henry Waxman has introduced H.R. 3616, which would define intermittent care to include one or more visits per day on a daily basis by a nurse or a home health aide for up to 90 days, and thereafter under exceptional circumstances, with monthly physician certification as to reasonableness and necessity. This bill would also provide for up to 20 visits by a home health aide after the need for skilled care no longer exists. The Heinz/Bentsen bill (S. 2338) would authorize daily visits for 60 days and a recent Heinz amendment would authorize 45 days. The Heinz amendment, however, only covers patients in a post-hospital setting and does not deal directly with the problem of persons who enter home care from a SNF or other non-hospital referral source and who can only receive limited home care due to restrictive interpretations of intermittent care by the FI. In such cases of restrictive interpretations the only way a client could become eligible for the 45-day coverage would be if he/she is admitted to a hospital and then discharged to home care.

POSITION ON THIS ISSUE: I endorse and urge immediate adoption of at least the Heinz amendment, and ideally the H.R. 3616 or S. 2338 provision. I speak for the National Association for Home Care when I say that they will continue to pursue a revision of the current HIM-11 guidelines, or adoption of an actual regulation, to make the intermittent care definition more congruent with Congressional intent and other regulations.

RATIONALE: The current guideline is not consistent with Congressional intent and other Medicare regulations and is being applied in varying and restrictive ways by various FIs.

SPECIFIC EXAMPLES OF THE PROBLEM:

One of the home health providers I queried about this problem sent me the following reply:

"...I would like to reiterate our problems with the 'intermittent care' interpretation. We would like to stress the cost effectiveness of home health care (even long-term daily care), as opposed to institutional care.

Our biggest problem, as with the rest of the country, is that our fiscal intermediary is denying all daily care visits over three weeks. The 'intermittent care' definition as it is now interpreted (only three weeks of daily visits maximum) poses many problems for agencies such as ours. With the advent of DRGs, we are now seeing much sicker patients being cared for at home and many of these patients will need daily visits for an extended period of time to prevent rehospitalization or nursing home placement. Patients are being sent home requiring more extensive treatments than ever before. Family members can be trained to assist in these procedures but, without daily professional supervision, the question of safe practice arises.

Patients with extensive wounds may also require daily treatments until healing is possible. Our agency was denied payment for 13 daily treatments to an elderly diabetic who had an infected foot wound, (post amputation of several toes), requiring daily treatments. Because of this patient's mental status and his substandard living conditions, as well as his being a diabetic, he was incapable of rendering his own care. Without these additional visits after the third week cut-off, the patient was in danger of a more extensive infection which would have required hospitalization and possible amputation of the foot.

Another instance involves a 53-year-old woman who suffered a massive brain hemorrhage and is in a chronic vegetative state. Without the help of home

BEST COPY AVAILABLE

health aides on a daily basis, the family would be forced to place the patient in a nursing home, again at a higher cost to the Medicare program. Please be aware: the cost of home health visit is $38 dollars a day. Compare this to the average cost of a hospital at $550 dollars per day.

Another factor to be considered is the increasing popularity of IV therapy and other highly technical procedures being performed at home. These patients may need daily supervision by a skilled professional for extensive periods of time--yet, the cost to the Medicare program will still be much less than if the person remained hospitalized as was traditionally done."

HOMEBOUND ISSUES

ISSUE #1: In July, 1983, HCFA was internally circulating a proposed new guideline that would change the Section 208.4 (HIM-11) guideline defining "homebound."

The new guideline would reverse the current presumption that a person need not be totally dependent and bedridden to be considered homebound. It would do so by deleting the current guideline wording that to be homebound "the condition of these patients should be such that there exists a normal inability to leave home and consequently, leaving their home would be a considerable and taxing effort." The current guideline allows the patient to be considered homebound if he has infrequent or short duration absences from the home primarily for medical treatment or "occasional nonmedical purposes" (e.g., trip to barber, a drive, walk around the block). I believe this is a reasonable approach which balances the ability to have limited activity while being essentially confined to one's home and eligible for Medicare home health benefits.

The new guideline would, in essence, only allow persons who are totally bedridden with no ability to get outside their homes to receive home health benefits. More specifically, under the new guideline, a quadriplegic, paraplegic, or severely handicapped person who leaves his home with the use of specialized transportation, supportive devices, or the help of several persons would not be eligible for the home care benefit under Medicare. One trip to church, to a store for groceries, to a dinner outside his home, or even to tend his own garden/yard--even with extraordinary assistance--would make him ineligible. The National Association for Home Care has been advised that several FIs are already using such a restrictive "bed-bound" guideline, as are several state Medicaid programs.

The National Association for Home Care met with HCFA representatives on September 15, 1983, and was assured no revised guideline would be issued unless and until there was industry input.

POSITION ON THIS ISSUE: The current guideline adequately balances the ability to have limited activity while being essentially confined to one's home and eligible for home care. The current guideline also gives FIs adequate authority to get documentation on "homebound" status, if and when needed.

RATIONALE:

(A) The law does not use "bed-bound" as the criteria for homebound. There is no indication of Congressional intent to have homebound equated to total immobility. It would be contrary to public policy to deny home care where it helps encourage limited social and physical mobility.

(B) NAHC has become increasingly aware of cases where the intermediary has denied payment on grounds that the client was not homebound.

Many of these cases are clearly ludicrous. For example, a paraplegic patient recently discharged from the hospital and certified as needing skilled nursing care was denied payment because a neighbor would come by periodically and wheel him to the grocery store.

(C) Denying claims on the basis of the fact that the patient is not homebound is a false savings. In many instances, patients are then transported to the emergency room of the local hospital at many times what Medicare would have paid for the home visit.

ISSUE #2: Some HHAs are being advised that if a person can get out of the home for kidney dialysis, IV therapy, or other care on an outpatient basis, they are not "homebound" per se.

POSITION ON THIS ISSUE: A per se blanket exclusion of persons as homebound who go out on a limited basis for medical care contradicts Section 208.4 of HIM-11. Such blanket exclusions should not be permitted.

BEST COPY AVAILABLE

RATIONALE:

Section 208.4 allows infrequent and short absences from the home, primarily for medical treatment. Independent of this guideline, it is contrary to humane and public policy considerations to consider that a person cannot receive home care for certain conditions, as certified as medically reasonable and necessary by his physician, and outpatient care for other conditions.

SPECIAL NOTE ON THE ABOVE ISSUES:

The change proposed is of a substantial nature. As such, it cannot be made with a mere change in the guidelines. Proposed regulations must be promulgated in the Federal Register and there must be opportunity for public comment. Only after considering these views and the best interests of the Medicare program can HCFA proceed. I agree with NAHC's contention that these new guidelines being considered are a back door cut of the benefits received by the nation's 31 million elderly and are definitely not in the best interests of the program.

LIBERALIZATION OF "SKILLED NURSING" IN HOME HEALTH BENEFIT

ISSUE: Every Congress going back to the 92nd Congress has gone on record in favor of an adjustment in the priority of government funding which has favored placing Medicare and Medicaid patients in institutions. Despite the progress that has been made toward encouragement of home care, the primary impediment to the delivery of home health services is a restrictive definition of "skilled nursing."

As a result of the general definition of skilled nursing in the law, FIs are applying varying and restrictive definitions, much as with "intermittent care." Some FIs are saying "skilled nursing" means "hands-on" care only and are denying any evaluation or assessment visits. Some FIs are saying if more than one visit a day is needed, then the care is not skilled care because institutional care is needed. And some are assuming that if a family member/relative/friend exists, he can be taught regardless of any assessment of the nature of the procedure and/or the person's abilities. Others are defining specific activities which HHAs believe require nurses, as those which either a home health aide, relative, or family member could do. And still other FIs are defining persons as "chronically unstable" and therefore not eligible for skilled nursing care because more than "intermittent skilled nursing care" is needed.

POSITION ON THE ISSUE: It should be government policy to take care of the aged and infirm first in their own homes where this is possible and only later, as a last resort--if and when they require 24-hour, around-the-clock nursing and supervision--should they be placed in long-term care facilities. The National Association for Home Care--and I, personally--earnestly support the liberalization of the term "skilled nursing" which, as currently applied, limits the number of Medicare beneficiaries who can qualify for home care under Medicare.

In some states, the Medicare interpretation of skilled nursing activity contradicts the State Nurse Practice Acts. Where these State Nurse Practice Acts are well-defined and less restrictive than the FI interpretation of skilled care, the State Act should prevail.

RATIONALE:

In its landmark 1974 report, "Nursing Home Care in the United States: Failure in Public Policy" (page 57), the United States Senate Committee on Aging concluded:

> "It is a cruel irony that more than 2.5 million people are in urgent need of home health services authorized under Medicare. But these individuals do not receive this care because few can qualify for 'skilled nursing care'."

The report noted that new and restricted definitions of the term "skilled nursing" had been imposed in 1969 and 1970, and that Senators Frank E. Moss, Edmund S. Muskie, and Frank Church had introduced legislation to liberalize Medicare home health benefits in 1973. In its recommendations, the 1974 report said "Eligibility for home health services should not be limited to those who qualify for skilled nursing care."

BEST COPY AVAILABLE

The report also included Persuasive evidence of the cost effectiveness of home care, saying:

> "Under Medicare, benefits are limited to a narrow and restrictive definition of skilled nursing. Under Medicaid, few states have made more than a token effort to make these services available. This glaring lack of policy is all the more evident when American health delivery services are compared with European systems where home health is a full partner in a genuine continuum of care."

The conclusions of the Senate Committee are just as valid today as they were in 1974, as is witnessed by the attention given to long-term care in the resolutions of the recent 1981 White House Conference on Aging.

In addition, during the latter part of 1983 the National Association for Home Care was advised by a home health agency in Kansas that its FI is applying a restrictive interpretation of the term "skilled nursing care." The result has been a rash of Medicare claims denials. The FI has been specifying that, despite a physician's certification of the need for a skilled nurse, the care given could have been given by a friend, family member, or home health aide.

The Kansas provider gave one denial example: The patient had a lung infection, no appropriate antibiotic had been found, her temperature was ranging between 100 and 104 degrees, and she had congestive heart failure. The nurse was treating and monitoring the heart and lung problems. The FI said the family could tell when there was a problem by using a thermometer and by watching for when the patient coughed.

WAIVER OF LIABILITY ISSUES

I. INABILITY TO APPEAL CLAIMS PAID UNDER WAIVER

ISSUE: Under current HCFA guidelines (Section 256, HIM-11), an HHA has no right to appeal a claim denial when it is paid on waiver. The rationale is that since the HHA was paid under waiver, the HHA has no liability, is not at risk, and therefore shouldn't have the right to appeal. This situation is exacerbated by the fact the denials are paid under and charged to waiver immediately before the opportunity for the administrative review or reconsideration procedure. And while this does not affect income during that quarter, it certainly influences waiver status in the subsequent quarter.

POSITION ON THIS ISSUE: HHAs are adversely affected by the lack of an appeal right and HCFA should not be allowed to create a prohibition against the right of appeal by using a "guideline" in the absence of any statutory or regulatory authority. HHAs should be given the right to directly appeal FI decisions to pay by waiver instead of regular payment.

RATIONALE:

First, there is no statutory or regulatory basis for the HCFA guideline. Second, the logic is incorrect because there is harm to HHAs. When claims are paid under waiver, they affect the HHA's waiver level and can push them over the 2.5 percent threshold. This can result in the loss of waiver, eligibility for Periodic Interim Payments (due to the inability to meet the "prompt submission of claims" requirement), and increase the administrative burden, all of which can have significant impact on cash flow, particulary for small agencies. Third, in the absence of statutory authority to the contrary, the HHA should have, as a matter of basic equity, the right to dispute an FI's decision on whether to pay a claim under normal payment or waiver.

II. INABILITY TO HAVE WAIVER STATUS RETROACTIVELY ADJUSTED

ISSUE: FIs currently are retroactively taking HHAs off waiver where they have found they made errors in honoring claims which should have been disallowed. But they will not retroactively restore an HHA's waiver where the FI (or an Administrative Law Judge) has reversed the claim denials which forced the HHA to lose its waiver. In one of many examples, a Chicago-based HHA lost its waiver because of 85 visit denials in one quarter. After going to hearings, a total of 87 percent of the denials were reversed. If there had been a retroactive adjustment to the affected quarter, the denial rate would have dropped from 4.66 percent to 1.86 percent. The HHA received reimbursement for the reversed denials, but there was no retroactive adjustment to restore waiver for the affected quarter and subsequent quarter.

BEST COPY AVAILABLE

POSITION ON THIS ISSUE: Intermediaries should be required to retroactively restore HHAs to waiver status where the FI's denial decisions which cause the loss of waiver are later reversed. FIs should not be allowed to retroactively take HHAs off waiver until the balancing right of retroactive restoration of waiver is in place.

RATIONALE:

There is nothing in the law, regulations, or even guidelines which either allows an FI to retroactively remove an HHA from waiver or prohibits an FI from retroactively restoring an HHA to waiver. Further, as a matter of basic equity, the HHA should not be penalized for the FI's errors. Visits which could have been paid under waiver in the affected quarters, but weren't due to the loss of waiver caused by FI error, should be paid.

III. REMOVAL OF MEDICARE WAIVER OF LIABILITY PROVISION

ISSUE: The President's FY 1984 budget proposal contained a recommendation that the Congress eliminate the waiver of provider liability provision which serves to protect hospitals, nursing homes, and home health agencies who have, in good faith, provided Medicare services to individuals who are later determined to be ineligible. The FY 1985 budget is expected to include a similar proposal.

POSITION ON THIS ISSUE: I oppose this proposed change and agree with the National Association for Home Care which believes the permissible rate of error should be changed back to 5 percent from the current 2.5 percent.

RATIONALE:

This provision was placed in the law to protect providers who, acting in good faith, could not have known that services furnished to certain individuals would not be compensated. In these cases, the Medicare program does nothing more than make the provider whole.

In the home health setting, in order for an agency to be compensated, its overall denial of claims rate must be less than 2.5 percent of the Medicare services given. Any agency which exceeds this limit is not reimbursed, irrespective of whether it accepted beneficiaries and acted in good faith. This requirement forces an agency to use due diligence in determining eligibility.

There is no evidence of abuse of this provision by home health agencies. The fact that only $10 million can be saved among hospitals, nursing homes, and home health agencies combined (if you accept the HHS estimate) by the deletion of this provision is testimony to the fact that there is little or no problem.

Furthermore, the National Association for Home Care believes that even the modest $10 million savings is not real because many denials are of a technical nature. Moreover, much of the Medicare data is not accurate. For example, many intermediaries do not even keep claims denial data under Medicare Part B.

This proposal was advanced by the Administration for the last three years and rejected by the Congress. Its enactment would serve to further undermine both public and provider confidence in the Medicare program. It would make accepting Medicare patients a kind of "Russian Roulette" at a time when more, rather than less, certainty and predictability is required. Given the vague application of constantly changing guidelines, directives, and regulations, it is difficult for HHAs to be 97.5 percent perfect in their determination of eligibility. Removing this requirement would demand that they be 100 percent perfect in their determination or suffer accordingly. Therefore, it is believed that Congress should restore the more realistic 5 percent of permissible error previously in law.

TECHNICAL DENIALS

ISSUE: HCFA policy has created a form of denial call "technical denials" and it is being imposed on HHAs. A "technical denial" is a denial of a visit based upon the FI's determination that the visit failed to meet a statutory or regulatory requirement, other than medical necessity. Technical denials are not subject to waiver of liability and are appealable only by the beneficiary (or the HHA when an HHA employee has been designated by the beneficiary as his representative--and HCFA is trying to stop this). Examples of technical denials would be ones where the FI finds the client did not meet the homebound or "in need of intermittent skilled nursing care" eligibility requirements or received a non-skilled or other service not covered under the Medicare home health benefit.

BEST COPY AVAILABLE

POSITION ON THE ISSUE: The "technical denial" should be abolished and HHAs given the right to appeal directly any claim denial, regardless of the basis of the denial.

RATIONALE:

The "technical denial" and the inability for HHAs to appeal such denials does not exist in the Medicare law or regulations. Since terms like "homebound", "intermittent", and "skilled nursing" are subject to multiple interpretations, the HHA should have the right to directly appeal such denials. Such "technical" terms are no more definitive than the term "medical necessity"--a term exempted from the technical denial policy. The HHA is harmed by such denials because they must absorb the cost of the services rendered and have no recourse to waiver or the appellate process for redress.

LACK OF SPECIFICITY IN DENIAL NOTICES

ISSUE: Some FIs are not stating "in detail" the basis for their denial determinations in their denial notices to HHAs despite a regulation requiring them to do so (42 CFR 405.702). FIs will often use pro forma language printed on a denial notice (e.g., "services non-compliant") instead of specifying the particular visit(s) which was denied and the specific reason. In some situations FIs issue "partial denials" which pay some of the visits and deny others without specifying which specific visits are being paid and which are being denied. The result is that HHAs do not have a reasonable basis to know what additional information is needed to pursue to review or appeal or how to orient employees on procedures to avoid future denials. The lack of specificity also creates more paperwork and slows down the entire claims process.

POSITION ON THE ISSUE: The regulation should be changed to:
(A) Require that either the denial notice and/or appropriate accompanying papers from the FI must specify each visit denied and the specific reason for each visit denial,
(B) Require that denial notices be sent to HHAs and patients in a timely manner, and
(C) Require that HHAs get notification of denials prior to, or at the very least, simutaneously with notification to patients.

RATIONALE:

The intent of 42 CFR 405.702 was to give the HHAs and beneficiaries a specific basis for requesting a review or appeal and initiating corrective action in staff policies/procedures where necessary. The lack of specificity subverts the intent of the regulation and the rights of the appellate process.

COORDINATION OF BENEFITS

(Selective Billing)

ISSUE: Some Fiscal Intermediaries (FIs) (particulary, I understand, in Vermont, New Hampshire, Wisconsin, and Minnesota) are telling Home Health Agencies (HHAs) that if patients are receiving coverage under Medicare, they cannot receive additional coverage from Medicaid or any other payment source (private insurance, self-pay, Title XX, etc.). For example, if patient A is receiving 3 hours of nursing care and 2 hours of aide care for 3 days a week, paid for by Medicare, but wishes to receive an additional 2 hours of nursing care the other 2 days to be paid by concerned relatives, Medicare will deny the Medicare coverage. Since most of these patients are financially dependent upon their Medicare coverage, this denial of coverage would force the patient to forego any extra care he might need, despite his ability to pay for the extra.

Medicare's convoluted logic for such denials is that if a person receives coverage beyond what Medicare will cover, then that person needs more than "intermittent care" and is ineligible for Medicare coverage. Thus Medicare is making a medical judgement--seeking to prescribe the need (i.e., the limits of intermittent care) and to be the second payor. This approach limits the availability of services to beneficiaries and availability of payment sources to beneficiaries and HHAs. The end result is either less care than needed or perhaps the forcing of a patient into an institution where Medicare would pay for all the care--even if it was then more than what was necessary.

BEST COPY AVAILABLE

POSITION ON THE ISSUE: A patient should be able to utilize multiple payment sources as long as the care being received is deemed medically necessary and reasonable and not duplicative of other care. Medicare should not be able to limit the extent of care a patient may receive merely because it exceeds the Medicare definition of need. A patient should be able to order and pay for whatever additional care he desires beyond Medicare without the fear of jeopardizing his Medicare benefit.

The National Association for Home Care requested a formal opinion on this issue from HHS in May of 1983. One year later this matter is still "under review" by HHS's Office of General Counsel.

RATIONALE:

There is no basis for such a policy in law, regulations, or HCFA manuals. It exceeds the authority granted to HCFA and its fiscal intermediaries. To allow such a policy to exist would make the Medicare benefit a "means-tested" benefit which is not the intent of the law. There are certain limited primary sources of payment which must be utilized before Medicare can pay. These are very limited under Section 116(b) of TEFRA and indicate that thereafter Medicare is the first and primary payor. There is no ban on use of other payment sources in conjunction with Medicare.

The current policy discriminates against home health agencies because it seeks to deny coordination of payment sources for benefits where such coordination is permitted for hospitals. The law makes no such distinction between hospitals and home health agencies.

Further, the current policy is illogical. Where the patient receives his Medicare-covered care from one HHA and other covered care (paid from non-Medicare sources) from another HHA, both HHAs are paid and the patient receives his full coverage from all payment sources. It is illogical not to allow such coordination of benefits where the care is being rendered through one HHA.

Care should be permitted to the fullest extent possible as long as it is medically reasonable and necessary and not duplicative. The patient's initial and ongoing certified plan of treatment by a physician is the initial and ongoing basis for determining whether the person requires "intermittent care." (See Section 1835(a) and 1814(a) of the Social Security Act, regulations (42 CFR 405.1633), and the stress on physician certification in Section 204.1 and 206.6 of HIM-11).

The fiscal intermediary is to make its judgment as to whether intermittent care is needed, the extent of the care, and duration of care based upon the physician's certification, plan of treatment, and clinical records--not on the nature of the Medicare bill. There is nothing which bars a home health agency from providing any type of home health service to a patient on a private pay basis. There is nothing which bars a provider from providing care, approved by the physician, to a patient who pays part by Medicare and part by private pay or other sources.

The selective billing ban presumes that where non-Medicare pay sources and Medicare sources are simultaneously used to cover home health services, the patient does not require "intermittent care" and the provider is trying to disguise that fact. That is an inequitable and unlawful assumption. FIs have access to all physician certifications and recertifications, to plans of treatment, and to clinical records. These reflect the type, intensity, and duration of care and should be used to determine whether, on a case-by-case basis, "intermittent care" is merited and being rendered. The billing process never was intended as a vehicle to reach a clinical judgment on intermittent care or any other clinically-based issue.

This policy also makes the patient and his family risk loss of Medicare coverage if they want to have more care than Medicare would allow. This seems to me to be neither reasonable, fair, nor, in some cases, medically wise.

You will note that this particular issue touches upon two others:

(a) intermittent care, and

(b) discrepancies in interpretations among FIs.

THE OFFICE OF DIRECT REIMBURSEMENT AND THE RIGHT OF PROVIDERS TO CHOOSE TO HAVE THEIR CLAIMS PROCESSED BY THE GOVERNMENT

ISSUE: The Anti-Fraud and Abuse Amendments of 1977, P.L. 95-142, contained a provision which authorized the Secretary of Health and Human Services to establish designated intermediaries for home health agencies in order to permit efficiency and economy in the Medicare program. I do not believe that by this

BEST COPY AVAILABLE

action Congress intended to phase out the right of providers to choose between having their claims processed by their designated intermediary or directly by the government through the Office of Direct Reimbursement (ODR). The Administration has sought to vitiate this right to a choice by abolishing ODR. The National Association for Home Care's Court challenge has sustained the legal right of providers to a choice but concluded that this right was based in 17 years of agency policy and not in statue.

POSITION ON THE ISSUE: I strongly urge support of legislation introduced by Congresswoman Barbara Mikulski (H.R. 2841) and Senator Paul Sarbanes (S. 1419) which would preserve ODR and the right of providers to choose between having their claims processed by their designated (statewide) intermediary or directly by the government through ODR.

RATIONALE:

ODR has been officially abolished and ODR providers are in the process of changing intermediaries. We do not, however, concede anything on our position that we have a legal right to ODR and that abolition of ODR is an illogical, costly, and otherwise counterproduction move. The rationale for preserving ODR includes the following points:

Out of 74 intermediaries used to process and pay Medicare claims nationwide in Fiscal Year 1982, ODR was second in terms of efficiency expressed in the second lowest adjusted cost per claim. In other words, it costs the 74 intermediaries anywhere from $2.28 to $4.86 to process each claim. ODR was the second lowest in cost to the government with an average cost of $2.73 per claim.

President Reagan's own Private Sector Task Force on Cost Control recommended retention of ODR in a report on the Department of Health and Human Services. In its report the task force said dismantling ODR "will remove any element of competition in serving claims...and will actually increase the cost [of the Medicare program] rather than produce savings."

The elimination of ODR would decrease competition among FIs be eliminating the second most efficient FI and eliminating a data and performance base by which to evaluate the other FIs. Of the 51 existing regional intermediaries for home health, at least 82 percent (42 FIs) are Blue Cross/Blue Shield. Elimination of ODR would only extend the concentration of this already existing virtual monopoly.

As a matter of public policy, it is important that the government should have some computer and claims processing capability in house:

--ODR has highly efficient and cost-effective computer and claims processing capability.

--ODR has the most comprehensive and accurate home health data base in the nation, which is needed to determine home health policy and reimbursement and benefit procedures.

--ODR provides the only mechanism to experiment in reducing claims processing costs, thereby reducing Medicare program administrative expenses.

--Elimination of ODR would limit patients' benefits to the arbitrary decision of a regional Fiscal Intermediary (82% of which are Blue Cross), with no internal HCFA check or balance on the intermediaries' performance.

Eliminating the office will cause a major disruption of services, especially to those providers which have purchased sophisticated computer systems to interface with ODR computers. The costs associated with shifting to another intermediary were estimated by the U.S. District Court at $10-$30 million. These costs will be passed on to the Medicare Program.

Eliminating the office will deprive the public of one of the best, most accurate, and impartial data bases in existence. If ODR is eliminated, the government will have to rely on what it is told by insurance companies and accept their statistics at face value.

REIMBURSEMENT FOR INTRAVENOUS THERAPIES

ISSUE: HHAs are being told in some states that one or more intravenous (IV) therapies are not covered under the Medicare Part A home health benefit. In one state, HHAs are being told no IV therapy (enteral, parenteral, antibiotic, chemo) is covered. Other states (particularly New Mexico, North Carolina, and Texas) are being told by FIs that no long-term enteral or parenteral therapy services or supplies are covered under the Medicare home health benefit and

BEST COPY AVAILABLE

that NG or levine tubes are considered prosthetic devices, billable only under Part B. Other FIs are being told visits will be paid for but not the supplies and equipment. And in still other states, HHAs are being told by FIs that visits involving hyperalimentation work will not be covered because patients are taught about hyperalimentation in hospitals.

POSITION ON THE ISSUE: All IV therapy visits, supplies, and equipment should be covered under the Medicare Part A home health benefit. The visits, including visits for hyperalimentation work, are skilled nursing care and should be allowable as long as they are medically reasonable and necessary as included in the plan of treatment.

RATIONALE:

There is nothing in the law, regulations, or guidelines which states that visits for IV therapies are not covered under the Medicare home health benefit. These conditions, like others, are covered as skilled nursing care under the Medicare home health benefit as long as the physician certifies the treatment as medically reasonable and necessary. The need for such skilled care will increase with the advent of the Medicare hospital DRG system which is already discharging sicker patients more quickly to home health providers.

Regarding supplies and equipment for IV therapies, even if NG or levine tubes (or other supplies used in IV therapies) are considered prosthetic devices covered under Part B (which is a debatable issue, to say the least), it in no way precludes coverage of the home health visit to treat the condition.

The net effect is to deny HHAs the ability to provide these services while permitting Part B suppliers, who are not licensed or supervised, to bill for these equipment/supplies (including a built-in labor cost), usually at higher rates than the HHA.

As regards hyperalimentation work, the law and regulations do not bar hyperalimentation or any other potential home care treatment on the presumption it should be done elsewhere. Furthermore, the Omnibus Reconciliation Act of 1980 removed the prior hospitalization requirement for home health coverage so there may be patients requiring hyperalimentation work who haven't been in the hospital. Even if a patient was discharged from the hospital and the hospital was supposed to do such training, it is irrelevant to an HHA doing it unless in the specific case it can be shown that the training was done in the hospital and done sufficiently recently to make home care hyperalimentation a duplicative service. Barring such a situation, the service should be allowable. to deny such claims would be contrary to the law, regulations, and the reality of health care.

Attached is a copy of the full text of Val J. Halamandaris' 01/24/84 letter to HCFA Administrator Dr. Carolyne Davis on this subject. (Mr. Halamandaris is President of the National Association for Home Care.)

REIMBURSEMENT FOR IV THERAPIES

ATTACHMENT

Dear Dr. Davis:

We are writing to object to recent directives by your agency and at least two fiscal intermediaries (Group Health Insurance, Inc. of Dallas, Texas and Blue Cross/Blue Shield of North Carolina) taking the position that parenteral/enteral therapy services, supplies and equipment are covered only as a prosthetic device (under Medicare Part B) and not as home health services under the Medicare Part A program. Enclosed herewith is a copy of the November 9, 1983 GHI Texas "newsletter", a draft of the December 9, 1983 BC/BS of North Carolina "bulletin", and a copy of the August 9, 1983 HCFA letter to the Blue Cross and Blue Shield Association — all of which reflect this new policy.

Our members in Texas, North Carolina, New Mexico and other states have advised us that intermediaries are telling them that certain intravenous (IV) therapies are not covered under the Mediare Part A home health benefit. In one state, the intermediary has advised home health agencies (HHAs) that the HCFA regional office has developed a new policy that no IV therapy (enteral, parenteral, antibiotic, chemo) will be covered under the Part A home health benefit. In other states HHAs are being told that no long term enteral or parenteral therapy services or supplies are covered under the Medicare home health benefit and that NG or levine tubes are considered prosthetic devices, billable only under Part B.

BEST COPY AVAILABLE

Other HHAs are being told visits will be paid for but not the supplies and equipment. And in other states, HHAs are being told by FIs that visits involving hyperalimentation work will not be covered because patients are taught about hyperalimentation in hospitals.

Let me make our position clear from the outset. We believe the policies set forth in your August 9, 1983 memo and the directives of the Texas, North Carolina, New Mexico and other intermediaries ar legally unsound. The law and regulations indicate that all IV therapy visits, supplies and equipment should be covered under the Medicare Part A home health benefit. Medical services and supplies provided to patients at home by a home health agency are covered under the home health benefit so long as the conditions for coverage are met and the services are not expressly excluded by some other provision of law. The mere fact that certain medical services are covered under Medicare as prosthetic devices does not preclude their coverage as home health services.

There is nothing in the law, regulations, or guidelines which states that visits for IV therapies are not covered under the Medicare home health benefit. These conditions, like others, are covered as skilled nursing care under the Medicare home health benefit as long as the physician certifies the treatment as medically reasonable and necessary. The need for such skilled care will increase with the advent of the Medicare hospital DRG system which already is discharging sicker patients more quickly to home health providers.

As regards supplies and equipment for IV therapies, even if NG or levine tubes (or other supplies used in IV therapies) are considered prosthetic devices covered under Part B (which is a debatable issue) it in no way precludes coverage of the home health visit to treat the condition.

The net effect is to deny HHAs the ability to provide these services while permitting Part B suppliers, who are not licensed or supervised, to bill for these equipment/supplies (including a built-in labor cost) usually at higher rates than the HHA.

As regards hyperalimentation work, the law and regulations do not bar hyperalimentation or any other potential home care treatment on the presumption it should be done elsewhere. Furthermore, the Omnibus Reconciliation Act of 1980 removed the prior hospitalization requirement for home health coverage so there may be patients requiring hyperalimentation work who haven't been in the hospital. Even if a patient was discharged from the hospital and the hospital was supposed to do such training, it is irrelevant to an HHA doing it unless in the specific case it can be shown that the training was done in the hospital and done sufficiently recently to make home care hyperalimentation a duplicative service. Barring such a situation, the service should be allowable. To deny such claims would be contrary to the law, regulations and the reality of health care.

Furthermore, if your agency believes its position is correct then you must recognize (as you have in internal documents) that this is a new policy which affects the rights of many beneficiaries and home health care providers. As such, it cannot be validly implemented by "letters", "bulletins", and "newsletters" requires a regulaton promulgated under the rulemaking requirements of the Administrative Procedure Act (5 U.S.C 553). In addition, the new policy results in a shift of business away from HHAs to Part B suppliers and has a substantial negative impact on small businesses. As such, it cannot be validly implemented without compliance with the small business impact requirement of Executive Order 12291 and the Reduction in Paperwork Act of 1980 (44 U.S.C. 3501, et. seq.).

It is our position that you and the intermediaries in question not only substantively are in error in your new policy, but procedurally already have violated the two laws and Executive Order cited above. Therefore, we are requesting that you (1) immediately advise all intermediaries that the August 9,1983 letter, other relevant HCFA directives and any policies based thereon are to be rescinded pending a review and (2) set up a meeting where your agency and our Association can discuss both procedural and substantive concerns before any further action is taken.

Let me now share with you a more detailed analysis which supports our position and the request outlined above.

BEST COPY AVAILABLE

I. Background

Parenteral and enteral nutritional therapy is required by patients who, due to illness or trauma, cannot ingest enough food orally to support normal activities of daily life. Parenteral therapy is required by patients who have lost the use of their intestinal tracts and involves administering nutrients each day through an in-dwelling catheter by means of a volumetric infusion pump.

Enteral therapy is required by patients who have a functioning intestinal tract but for whom regular oral feeding is impossible. Enteral therapy is administered through nasogastric, jejunostomy or gastrostomy feeding tubes by means of an electronic flow controller or by gravity.[1]

The services, supplies, and equipment commonly used in parenteral/enteral therapy include the following:

A. Services

(1) Consultation with hospital personnel in establishing the patient protocol fo home therapy.

(2) The provision of home training in the hospital if necessary.

(3) Additional instruction in the patient's home at the time of discharge from the hospital.

(4) The provision of all equipment and supplies, including parenteral or enteral solutions.

(5) Registered pharmacists and nurses on call at all times to meet patient needs.

(6) Delivery of all solutions and equipment to the patient's home.

(7) Periodic follow-up by nurses and pharmacists, to assure patient compliance with the home regimen.[2]

B. Supplies and Equipment

(1) Catheters
(2) Filters
(3) Extension Tubing
(4) Infusion Bottles
(5) Pumps (either feed or infusion)
(6) I.V. Poles
(7) Needles
(8) Syringes
(9) Dressings
(10) Tape
(11) Heparin Sodium (parenteral only)
(12) Volumetric Monitors (parenteral only)
(13) Concentrated Nutrients
(14) Enteral nutritional preparation
(15) Liquid Diet (for catheter administration)[3]

Parenteral and enteral nutritional services, supplies, and equipment have been "ordinarily furnished" by hospitals to inpatients for many years and, accordingly, they have been covered under Part A of the Medicare program as hospital inpatient services since 1976.[4] At least until 1981, HCFA permitted parenteral and enteral therapy service furnished in the home setting to be covered under the home health benefit.

In July 1981, HCFA issued revisions to the Medicare Carriers Manual which stated that parenteral and enteral therapy equipment and supplies furnished in other than the hospital inpatient setting were to be covered under Part B of the Medicare program as "prosthetic devices."[5]

In a memorandum dated July 26, 1982, HCFA stated that parenteral and enteral therapy, supplies, and equipment could not be covered as prosthetic devices if the patient's functional impairment is likely to be temporary rather than permanent in nature.[6] Accordingly, these Manual provisions and the July 26, 1982 policy

BEST COPY AVAILABLE

memorandum appear to be the sources of the recent interpretations by HCFA and the Texas intermediary.

II. Legal Analysis

A. Parenteral/Enteral Therapy is Covered as a Home Health Service

(1) Coverage as home health "medical supplies" or "medical appliances"

HCFA's position that parenteral and enteral therapy services cannot be covered as "home health services" because they are covered exclusively as prosthetic devices is inconsistent with Medicare law and HCFA's own prior interpretations of the law. In fact, parenteral and enteral therapy services are covered as home health services if they meet the criteria for coverage and are not expressly excluded from coverage by some other provision of Medicare law.

"Home health services" are covered under Title XVIII of the Social Security Act. 42 U.S.C. Subsection 1395d(a)(1) and 1395k(a)(2)(A). The term is defined to include "part-time or intermittent nursing care" and "services of home health aide," "medical supplies (other than drugs and biologicals)," and "the use of medical appliances." 42 U.S.C. Section 1395x(m)(1), (4), and (5); 42 C.F.R. Section 405.236(a), (d) and (e).

According to HCFA's instructions, "medical supplies" means:

> Items which, due to their therapeutic or diagnostic characteristics, are essential in enabling home health agency personnel to carry out effectively the care which the physician has ordered for the treatment or diagnosis of the patient's illness or injury.

Home Health Agency Manual Section 206.3.A. Examples of items which HCFA considers to be "obviously" medical supplies are catheters, needles, syringes, surgical dressings, adhesive bandages, materials used for dressings such as cotton gauze, and materials used for aseptic techniques. Id. Other items which HCFA also considers included within the term "medical supplies" are irrigating solutions, intravenous fluids, and oxygen. Id. Thus, the supplies which HCFA has identified as being ordinarily provided in parenteral and enteral therapy are either explicitly or implicitly included as medical supplies under the home health benefit.

The equipment needed to administer parenteral and enteral therapy in the home similarly falls within the definition of home health services. According to HCFA's instructions, medical appliances which may be covered as a part of home health services include items of medical equipment:

(a) owned or rented by the home health agency;

(b) placed in the patient's home to facilitate his treatment and rehabilitation under a home health plan;

(c) capable of withstanding repeated use;

(d) primarily and customarily used to serve a medical purpose; and

(e) generally not useful to a person in the absence of illness or injury.

Home Health Agency Manual Section 206.3(B). Infusion bottles, I.V. poles, volumetric monitors, and infusion pumps, which HCFA acknowledges are ordinarily furnished in parenteral and enteral therapy, clearly would be included in the definition of medical appliances set forth in the Home Health Agency Manual.

(2) Parenteral and enteral therapy services, supplies, and equipment are not excluded from the home health benefit

Items and services which are encompassed within the definition of home health services are covered under Medicare if certain conditions for coverage are met. The patient must be under the care of a physician and confined to his home. 42 U.S.C. Section 1395f(a)(2)(D); 42 C.F.R. Section 405.234; Home Health Agency Manual Section 208. The items and

BEST COPY AVAILABLE

services must be furnished by a participating home health agency or by others under arrangements made by the home health agency; they must be furnished under a plan of care; and they may not be expressly excluded from coverage by some other provision of Medicare law. Id.

Items and services which are expressly excluded from covered home health services are:

(a) items and services which would not be covered as inpatient hospital service if they were furnished by a hospital,

(b) transportation services, and

(c) housekeeping services.

42 C.F.R. Section 405.237. Items and services furnished by a hospital to inpatients qualify for coverage as inpatient hospital services if they are the types of items and services which are ordinarily furnished by a hospital to its inpatients. See 42 C.F.R. Subsection 409.14 and 409.16. HCFA has acknowledged in regulations and in reports that parenteral and enteral therapy services, supplies, and equipment are ordinarily provided by hospitals to their inpatients. 42 C.F.R. Section 405.310(m)(2)(v); Home Parenteral and Enteral Nutrition Support Services, 1. Thus, the parenteral and enteral therapy services, supplies, and equipment which are commonly provided to patients in their homes do not fall within any specific exclusion from the home health benefit.

There are general exclusions for a variety of services which are otherwise covered under Medicare such as: services which are not reasonable and necessary for the diagnosis and treatment of illness or injury or to the functioning of a malformed body member, custodial care, and personal comfort items, among others. 42 U.S.C. Section 1395y(a); 42 C.F.R. Section 405.310. So long as parenteral and enteral therapy services, supplies and equipment meet the definition of home health services and do not fall within one of the specific or general exclusions to coverage, those services should be covered under Medicare as "home health services."

Significantly, and unfortunately for HCFA's position, there is no provision in the statute or regulations which would permit denying coverage under the home health benefit merely because parenteral and enteral therapy services, supplies and equipment are also covered under Part B of the Medicare program as prosthetic devices.

B. Significance of HCFA's Position

HCFA has taken the position in instructions and policy memoranda that parenteral and enteral therapy services, supplies and equipment are covered exclusively as prosthetic devices. Prosthetic devices are one of the types of items included under the category of "medical and other health services" covered under Part B of the Medicare program. 42 U.S.C. Subsection 1395k(a)(1) and 1395x(s). Covering parenteral and enteral therapy items and services exclusively as prosthetic devices has several significant consequences. Medicare reimburses only 80% of the reasonable charge for prosthetic devices but 100% of the reasonable cost or reasonable charge for home health services. There is an initial deductible amount which Medicare does not pay for prosthetic devices and are not reimbursed (except to the extent the costs are contained in the reasonable charge for the items supplied) while part-time or intermittent nursing care is covered under the home health benefit. Finally, prosthetic devices are covered according to HCFA instructions, only where they replace all or part of the function of a "permanently" inoperative or malfunctioning internal body organ while home health services may be covered if they are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. 42 U.S.C Section 1395y(a)(1)(A). Thus, acknowledgment by HCFA that parenteral and enteral therapy services are covered as home health services will result in those services being more accessible to a greater number of patients outside of the hospital setting.

BEST COPY AVAILABLE

C. Deficiencies in HCFA's Policy

HCFA's position with respect to parenteral/enteral therapy is deficient in the following ways:

(1) As discussed, the policy has no support in the law pertaining to the coverage of home health services.

(2) It represents a reversal of HCFA's policy with respect to services covered under both Part A and Part B of the Medicare program.

(3) It is inconsistent with HCFA's own instructions.

(4) It is inconsistent with HCFA's prior interpretations and practice.

(5) It violates the rulemaking provisions of the Administrative Procedure Act and the provision of Executive Order 12291 and the Reduction of Paperwork Act of 1980.

(6) It is contrary to public policy and HCFA's objective of reducing costs under the Medicare program.

In addition to lacking support in the rules defining coverage of home health services, HCFA's position represents a reversal of its prior policy with respect to concurrent coverage of services under more than one provision of the Medicare program. Many patient services can be covered under more than one provision of Medicare. For example, "home health services" are covered under both Part A and Part B.[9] Many of the specific items and services covered under Part B as "medical and other health services" are also included in the definition of "home health services" (e.g., diagnostic services,[10] outpatient physical therapy and speech pathology services,[11] durable medical equipment,[12] and surgical dressings.[13]) Perhaps most significantly, many of the items and services included within the definition of "prosthetic devices" under the medical and other health services benefit are also expressly included under the home health benefit (e.g., catheters, needles, syringes, dressings, and tape).[14]

In the past, HCFA has taken the position that if the patient is eligible for coverage of home health services under both Part A and Part B of the Medicare program, coverage and payment will be deemed to be under Part A. Home Health Agency Manual Section 208.3. Where services could be covered as home health services under Part A and as medical and other health services under Part B, HCFA has permitted the patient to choose the coverage he desires. 42 C.F.R. Section 405.239 and Home Health Agency Manual Section 222. Accordingly, HCFA's recent position that parenteral and enteral therapy services may be covered only as prosthetic devices under the medical and other health services benefit is a dramatic reversal of its prior policy.

A recent report indicates that HCFA recognizes that its policy with respect to coverage of parenteral and enteral therapy services is internally inconsistent. The HCFA Chicago Regional Office stated in a report dated March 1, 1983 that Section 2130 of the Medicare Carriers Manual defines prosthetic device to mean a device that replaces a "permanently" inoperative or malfunctioning body organ while the Medicare Carriers Manual Coverage Issues Appendix Section 65-10 "clearly acknowledges the therapeutic potential and possible temporary nature of parenteral and enteral therapy."[15] The report observes that the Coverage Issue Appendix lists numerous diagnoses which are not permanent conditions (e.g., jaw fracture) and numerous chronic conditions for which parenteral and enteral therapy may not be needed permanently (e.g., acute ulcerative colitis) as diagnoses and conditions which would warrant the use of covered parenteral and enteral therapy services. The report also notes that the relevant medical literature supports the concept that parenteral and enteral nutrition therapy is appropriate on a temporary basis to accelerate healing and recovery from certain conditions.

Further, according to a survey conducted by the HCFA Chicago Office, most carriers have been relying upon the broader coverage described in the Coverage Issues Appendix rather than on the more narrow coverage conditions contained in the Manual definition of prosthetic devices. The Chicago Regional Office, therefore, concluded:

BEST COPY AVAILABLE

> The instructions provided in the Medicare Carriers Manual are ambiguous and provide ineffective guidance.

Home Parenteral and Enteral Nutrition Support Services, Executive Summary, 1.

In addition, the survey conducted by the Chicago Regional Office revealed that many carriers are reimbursing parenteral and enteral therapy services, supplies and equipment under the home health benefit. A letter from the HCFA Office of Coverage Policy to the Blue Cross/Blue Shield Association as recently as August 9, 1983 referred to "two Bureau reponses indicating coverage for related nursing services and hyperalimentation supplies under Medicare's home health benefit." (Attachment B). Finally, the recent newsletters from the Texas state-wide intermediary states that because parenteral and enteral therapy may be used to treat a <u>permanent</u> impairment, the therapy cannot be covered as a home health service; however, nursing services involved in "teaching visits for short-term enteral therapy may be covered as home health services." (Attachment A). Thus, conflicting instructions from HCFA have resulted in arbitrary and capricious coverage policies and decisions by the intermediaries.

Even assuming that HCFA corrects the inconsistencies in its instructions and fully implements its more restrictive policy with respect to coverage of parenteral and enteral therapy services, it may not do so without complying with the rulemaking requirements of the Administrative Procedure Act as explained in D below.

Finally, covering parenteral and enteral therapy services exclusively as prosthetic devices is contrary to public policy and creates incentives for higher costs to the Medicare program. The HCFA Regional Office concluded after studying the issue:

> It is clear that the therapeutic and/or life-sustaining value of total nutritional support should be available to more patients than the prosthetic device benefit would allow.

Home Parenteral and Enteral Nutrition Support Services, 20-21. Under HCFA's new policy, patients in need of parenteral and enteral therapy who cannot meet the prosthetic device coverage requirements will have to go without the services or receive them as hospital in-patients. Even the patients who are able to meet the prosthetic device coverage requirements will be penalized by having to pay the deductible and twenty percent co-insurance amounts for Part B services.[16]

HCFA's policy is contrary to the objective of reducing costs of services to the Medicare program because it has the effect of driving more patients to receive the needed services as in-patients of hospitals where the cost of therapy is recognized to be more than twice the cost of the same therapy provided in the home setting.[17]

HCFA's policy is contrary to the objective of reducing costs of services to the Medicare program because it has the effect of driving more patients to receive the needed services as in-patients of hospitals where the cost of therapy is recognized to be more than twice the cost of the same therapy provided in the home setting.[17]

HCFA's policy is sound to the extent that it broadens Medicare coverage to include prenteral and enteral therapy as a prosthetic device because it permits coverage of the services, supplies and equipment when rendered by suppliers. However, there is no legal or public policy rationale to support the proposition that coverage of prenteral and enteral therapy services, supplies and equipment as prosthetic devices precludes their coverage as home health services.

D. HCFA's Policy Violates the Rulemaking Requirements of the Administrative Procedure Act

HCFA has acknowledged ininternal documents that its policy reverses its prior interpretation of the law and will affect the rights of many beneficiaries in home health agencies.[18] It is well established that changes in existing interpretations of the law and changes in policy which will have a

BEST COPY AVAILABLE

substantial impact on the rights and interests of private parties, must be promulgated in accordance with the rulemaking requirements of the Administrative Procedure Act, 5 U.S.C Section 553. National Association of Home Health Agencies v. Schweiker, 690 F. 2nd 932 (D.C. Cir. 1982), cert. denied, 103 S.Ct. 1193, ___ U.S. ___ (1983); Batterton v. Marshall, 648 F. 2d 694, 708-09 n. 83 (D.C. Cir. 1980). Accordingly, whatever policy HCFA ultimately adopts, that policy cannot be validly implemented without being published in the Federal Register with an opportunity for public comment.

We are available to meet at your convenience and hope you will honor our request to meet as soon as possible.

Sincerely,

Val J. Halamandaris
President

FOOTNOTES

(1) A Research Paper: Home Parenteral and Enteral Nutrition Support Services, Operational Review Branch, Division of Health Standards and Quality, Health Care Financing Administration, Region V, (March 1, 1983), 1.

(2) Home Parenteral and Nutrition Support Services, 11.

(3) Medicare Carriers Manual Section 2130.A.

(4) Home Parenteral and Enteral Nutrition Support Services, 1 and 3; 42 C.F.R. Subsection 409.14 and 409.16.

(5) Medicare Carriers Manual Section 2130.A and Coverage Issues Appendix Section 65-10.

(6) Office of Coverage Policy, Bureau of Program Policy, HFA, Memorandum, Prosthetic Devices, July 26, 1982.

(7) Medicare Carriers Manual, Coverage Issues Appendix Section 65.10, Office of Coverage Policy, Bureau of Program Policy, HCFA, Memorandum, Prosthetic Devices, (July 26, 1982); Office of Coverage Policy, Bureau of Program Policy, HCFA, Memorandum, Parenteral and Enteral Nutritional Therapy (Oct. 26, 1982); Letter from Robert Streimer, Director, Office of Coverage Policy, Bureau of Eligibility, Reimbursement and Coverage, HCFA (Aug. 9, 1983) (Attachment B).

(8) The "permanent" requirement for coverage of prosthetic devices is not set forth in the statute or regulation but appears only in the HCFA instructions. Compare 42 U.S.C Section 1395x(s)(8) and 42 C.F.R. Section 405.2310(h) with Medicare Carriers Manual Section 2130.

(9) See 42 U.S.C. Section 1395d(a)(3) and 42 U.S.C. Section 1395k(a)(2)(A).

(10) Compare 42 U.S.C. Section 1395x(s)(C) and 42 C.F.R. Section 405.2310(k) with 42 U.S.C Section 1395x(m) and 42 C.F.R. Section 405.236(g).

(11) Compare 42 U.S.C. Section 1395x(s)(D) and 42 C.F.R. Section 405.231(m) with 42 U.S.C. Section 1395x(m)(2) and 42 C.F.R. Subsection 405.236(b) and 405.239.

(12) Compare 42 U.S.C. Section 1395x(s)(6) and 42 C.F.R. Section 405.231(g) with 42 U.S.C Section 1395x(m)(5); 42 C.F.R. Secton 405.236(e) and Home Health Agency Manual Section 206.3.B.

(13) Compare 42 U.S.C. Section 1395x(s)(5) and 42 C.F.R. Section 405.231(f) with 42 U.S.C. Section 1395x(m)(5); 42 C.F.R. Section 405.236(e) and Home Health Agency Manual Section 206.3.A.

(14) Compare Medicare Carriers Manual Section 2130.A with Home Health Agency Manual Section 206.3.A.

BEST COPY AVAILABLE

(15) Home Parenteral and Enteral Nutrition Support Services, 13.

(16) Even HCFA recognizes that coverage of items and services under Part B rather than under Part A as home health services is "disadvantageous to the beneficiary." Home Health Agency Manual Section 222.

(17) Home Parenteral and Enteral Nutrition Support Services, 2.

(18) See letter of August 9, 1983 from Director, Office of Coverage Policy, HCFA, stating that the new policy "supersedes" the prior policy permitting coverage of parenteral and enteral therapy services under the home health benefit. (Attachment B) See also Home Parenteral and Enteral Nutrition Support Services, 2-3, 12.

OCTOBER 26, 1982, REGULATIONS ARE OVERBROAD:
WOULD BAR NON-COMPENSATED PHYSICIANS SITTING ON
HOME HEALTH AGENCY BOARDS FROM CERTIFYING PATIENTS

ISSUE: The Federal Register of October 26, 1982, contained a rule that amended Sectin 405.1633 of the Conditions of Participation for Home Health Agencies to specify that certification of need for home health services may not be performed by any physician having a "significant ownership interest in, or a significant or contractual relationship with, the home health agency." It further states that aphysician who is a director of a home health agency would be considered to have a significant ownership interest even if he voluntarily serves on the HHA board without compensation. Under this regulation, effective November 1, 1982, volunteer physicians on HHA boards have not been able to refer their patients or prepare plans of treatment to the HHA upon whose board they serve.

The rule, as published, appears to apply to physicians who serve on the boards of directors of tax-exempt, voluntary, non-profit home health agencies, such as visiting nurse associations. Directors of these agencies are prohibited by the Internal Revenue Code from receiving any payment for service as a director or from receiving any share of a surplus resulting from agency operations. Any such surplus must be used for the agency's non-profit purposes.

The National Association for Home Care strenously objected to the overbreadth of this regulation. HCFA, as early as January, 1983, agreed in writing that the regulation was overbroad and agreed to revise it accordingly. HCFA has made this revision and has made it retroactive, It is currently awaiting signature by the HHS Secretary.

Congresswoman Olympia Snowe (R-ME) introduced legislation which would allow physicians who serve in an uncompensated capacity as officers or directors on HHA boards to prepare plans of care and certify clients for home care at their agencies (H.R. 3603). This bill would amend the enabling legislation retroactively. The Senate Budget Committee Report accompanying the proposed Omnibus Reconciliation Act of 1983 (S. 2062) contains a similar provision, but is not retroactive.

POSITION ON THE ISSUE: HCFA's rule on this matter was published in interim-final form and was effective at once. It has had--and still is having--a devasting effect all across the nation, particularly among tax-exempt and/or voluntary non-profit home health agencies, such as mine.

This regulation has created some serious problems for our agency and has the potential to create even more. It is difficult enough to get physicians to take time from their busy schedules to oversee and advise us on the quality of our services--a function which we believe is vital to the continued provision of quality home health care. To deprive us of these physicians as referral sources seriously jeopardizes our ability to serve the population of Mississippi. As the regulation is written, any physician interested enough to serve our agency as an advisory board member is forced to utilize another home health agency for his patients. This is ludicrous.

HCFA's revision will allow physicians who serve as uncompensated members of agency boards to continue certification. Such a change is, however, inadequate. In the first place, what is "compensation?" In our agency, we have physicians who serve on our advisory board in an essentially voluntary capacity. They meet triannually and we pay for their travel to and dinner at the meetings. Is this "compensation?" Our Medical Director, who founded our agency in 1969, served on our Board of Directors until the issuance of this regulation. Since

BEST COPY AVAILABLE

we are a private, non-profit corporation, he has no "significant ownership interest" in our agency, but does receive an hourly compensation as a part-time employee. Should he be barred from referring patients to his "own" agency? His referrals make up less than 1% of our total referrals.

S.2062 also does not adequately address our problem. This provision would permit a physician who has a financial interest in a home health agency which is a sole community provider to carry out the certification and plan-of-care functions for patients who will receive services from the agency. However, in Mississippi at least, almost every area in the state is served by at least 2 home health providers because of the State Health Department branches in each county. Thus under this revision, no private home health provider could qualify. Yet, if they couldn't, then some areas might be left with only one alternative--to receive their care from the State Health Department. This should not be taken as a slur upon their services, but simply as a reasonable and fair protest against depriving patients of a freedom of choice among various home health providers.

I fully understand the rationale behind the original HCFA regulation and applaude their efforts to control the fraud and abuse within agencies where a particular physician receiving compensation is the major referral source for that agency. This should be monitored. I believe, however, that rather than barring physicians receiving any compensation from making referrals, the HCFA regulations should set a percentage of total agency referrals which can be made by physicians receiving some form of significant compensation. And we do not believe that travel and dinner are "significant" under this definition--nor is part-time employee compensation for our Medical Director's services, as long as his referrals comprised less than the 1% of total agency referrals. I believe that this would be fair for all concerned, would successfully limit any abuse, and would ensure that an agency would be able to continue offering quality health care--by not reducing the number of referrals it was allowed to accept and by not discouraging physician supervision.

Home health agencies are in a crisis situation due to having to suspend physicians from their boards. This suspension could drastically affect our ability to provide needed home health care--in the quantity, as well as the quality, desirable.

RATIONALE:

This position is required as a matter of basic equity. Any solution must be made retroactive since HCFA admitted the error of its position from the outset and took no corrective action, and since many HHAs have been severely penalized financially because of the inappropriate application of this regulation.

THE NEED FOR PEDIATRIC HOME CARE

ISSUE: The recent Surgeon General's Conferences held December, 1982, and December, 1983, brought to light the fact that thousands of children and young people are being retained in the hospital longer than necessary simply because of the absence of alternatives. Institutions such as Children's Hospital in the District of Columbia have begun to establish pediatric home care units which provide for continuity of care when youngsters are returned home. Groups such as the National Association for the Severely Handicapped and the National Association for Social Work have recently sponsored conferences on the topic. In additional, Senator Orrin Hatch (R-UT) held hearings on this subject in August, 1983, in Salt Lake City, Utah. The conferences, hearings, and reports have all emphasized that home health agencies can care for young people at far less cost and can make it possible for them to remain with their families.

POSITION ON THE ISSUE: The efficacy of home health care for the elderly has been established beyond a reasonable doubt. I believe that home health care can be equally beneficial for children--indeed, for people of all ages. Therefore I speak for the National Association for Home Care, as well as for myself, when I say that I favor the expansion of maternal and child welfare programs to provide home care coverage for mothers and children. However, a clarification is needed of existing definitions and policy which would provide coverage of many needy and infirm youngsters under the Medicare act. Many of these young people are clearly disabled by any reasonable interpretation of that term, yet they are not considered "disabled" under Medicare's definition. Another Medicare requirement relates to restoration of loss of function. HCFA rules bar home care services to young people on the grounds they have yet to establish certain functions and therefore there is nothing to restore. This

BEST COPY AVAILABLE

is rather tortuous reasoning and results in the abandonment of many children to a life which may fail to reach its full potential. The National Association for Home Care plans to issue a report on pediatric home care with legislative and regulatory recommendations some time this year. I hope that this report will be given careful attention and study and that appropriate regulations will be written to correct what has basically been an oversight in providing the best and most appropriate care for the children of this country.

RATIONALE:

(A) There is a nationwide concern about ever-escalating hospital costs. One way to reduce these costs is to move many young children presently hospitalized into their own homes.

(B) Home care is appropriate for thousands of youngsters but is not being received because of the unavailability of financial support.

(C) Monies invested in home care would result in savings to the government, families, and third-party payors by reducing hospital stays. It would also serve to reunite children with their families--which is an incalculable emotional benefit for all concerned--and cause the use of hospital beds only when really necessary.

(D) The above rationale may be applied equally to nursing home costs in some cases and I would also suggest that private insurance companies be strongly urged to provide their own home health coverage as a cost-efficient alternative to institutional care. One should not forget the Katie Becket case....

Ms. WILLIAMS. In addition, the problem that Mr. Baxter has referred to, differences in interpretation of regulations by the fiscal intermediaries and the regional office, while we're not saying that one, the more stringent or the more flexible rules are better than the other, we do believe that the rules could be consistent regardless of who's carrying them out.

Again, we appreciate the opportunity to come here today.

Senator COCHRAN. Thank you very much, Ms. Williams, for being here and for helping in the way you have. We appreciate Ms. Burchfield being here. Do you have any additional comments that you would like to make? We'd like for you to feel free to make them at this time.

Ms. BURCHFIELD. I realize that you are pressed for time today. All our comments are well documented in here. I do have a few problems—I would like to get this back to the issue which is the problem of HCFA and, you know, I don't want to get into a game of which office should have home health.

Senator COCHRAN. Right.

Ms. BURCHFIELD. We do have problems here and we do, throughout our written testimony here, refer to the National Association for Home Care, from which we got a lot of our basic information. We have tried to also take that information and portray what's going on in Mississippi.

On page 6 of this testimony which you will find in here, you will find that there's a new provision that robs the beneficiary and the provider both in that it nullifies the procedural rights of providers, but also nullifies the legal and constitutional rights of medicare patients to an effective appeal when an intermediary decides not to pay their medicare bill. What we're seeing happening and what I'm seeing in my particular agency, as we all are throughout the State, is that if there are any visits denied by medicare on a patient, the provider, the home health provider, is no longer able to intercede on behalf of that beneficiary. It has

BEST COPY AVAILABLE

to be by the beneficiary. They are not all able to do this. The existing HIM-11 "does not address the issue of beneficiary designation of a home health agency employee as his/her representative. However, current regulations specifically state that beneficiaries whose claims are denied are allowed to designate an employee of the home health agency." What we're seeing is this does not apply to hospitals, social workers, other entities of this nature. They are still provided the right to appeal on behalf of the patient. It is addressed strictly to home health providers. We feel our beneficiaries are being cheated in a manner, that they are not all able to—I have patients in my own agency that this has really hurt them. We are not able to appeal for them. We feel that this "guideline violates the equal protection clause of the U.S. Constitution by singling out home health agency employees and denying them the ability to act as designees of the beneficiary. Employees of hospitals, nursing homes, and other providers still retain the right of designation." This has been singled out just for home health and it has hurt our beneficiaries and it has hindered us when we feel we have a good case that we could argue or appeal to the intermediary through perhaps our lack of documentation that the denial was made. We can no longer do that. The beneficiary is not always able, nor does he always have family capable of doing this. So, you know, I think it's a real detriment to the patient himself.

I think we've all talked over and over about the homebound status. We do have on page 9 here the issue about homebound. We feel that the law does not use bedbound as a requirement; however, we're seeing that a lot as a requirement of the State of Mississippi. It's not spelled out in the law as such, and the idea is if the patient can get out and walk around the block with his walker, he does not qualify for home health.We feel that there are many patients out there who do. We feel that it would be contrary to public policy to deny home care where it helps encourage limited social and physical activity. We feel that's contrary to the whole concept of home health care to begin with.

"Denying claims on the basis of the fact that the patient is not homebound is a false savings. In many instances, patients are then transported to the emergency room of the local hospital at many times what medicare would have paid for the home visit." So there's a lot of conflicts here. There are a lot of conflicts that we have discussed before, that we discussed in March in Washington on skilled nursing limitations and liberalization of skilled nursing. We feel that there are some reports in here that would be of special interest to you. There are many patients out there who need home health but, again, we come in with fiscal intermediaries' interpretations of skilled care as hands-on care, not assessments, not evaluations. There are a lot of problems within the system. We feel these documents here should give you the background you need. We would be glad to answer questions for you, but we have provided you with as much as we could of the different issues, most of which came from the national association and also how it reflects in the State of Mississippi.

BEST COPY AVAILABLE

Senator COCHRAN. Thank you very much, Ms. Burchfield.

Mr. BAXTER. I've got one comment I'd like to make as far as the statistics presented to the subcommittee by the Mississippi Hospital Association relative to costs of home care.

Senator COCHRAN. Now, y'all don't fight.

Mr. BAXTER. I'm not going to fight. I would just like to inform the subcommittee that there are certain statements that are untrue about the data and the first two pages of the data do not accurately reflect the truth.

Thank you.

Senator WEICKER. Let me ask one question of any of you. As I receive testimony in Washington—I'm sure one of you has the exact statistic—what is supposed to happen to our elderly population by 1990 and then again by 2010? Isn't it expected to double? Do you have those?

Ms. BURCHFIELD. If I'm not mistaken, at the present time it's one out of five are over 65 and by the year 2025 it will be one out of three. If I'm not mistaken, I read that in Home Health.

Senator WEICKER. Well, these are spectacular statistics, and I remember just within the very short span of the last decade, when, indeed, the problems of the elderly were treated in mental institutions rather than hospitals, and I just have to wonder as to whether or not we're going to be prepared for this explosion. I don't think we are. I don't think anyone is planning for it whatsoever. I know that in my interviews also with the universities and the medical schools, only a few of them have courses for their students specializing in this area. And it has to be the most—the largest eminent problem that's going to confront this Nation, and it seems to me that the home care area is the only place where it can be taken care of. We're just not physically equipped to handle it.

Mr. BAXTER. I think that's one of the reasons that home health is being looked to more and more. We've got to have some way to take care of the elderly population in the future years. One of the things that none of us managed to get out in our testimony was currently there are people who are falling through the cracks. You know, there are currently people that are in the straits, do not get care from rural health initiatives, cannot get it from the hospitals, cannot get it from nursing homes, and cannot get it from home health agencies. So while the problem in the future may be more dramatic and certainly one to think about, I am concerned with today. Today we've got problems.

Ms. WILLIAMS. I just think you're right, Senator Weicker, in the statistics for the elderly, but particularly for those over age 85. That's the population that is increasing at such a fast rate. And I think the statistics that I saw was if we built in this country one nursing home, complete facility, every day between now and the end of the century, we could not begin to meet the needs in the nursing home environment, so we will have to do it in the home environment.

Senator COCHRAN. Well, I'm convinced that we need to be sensitive to ensure that the Federal laws don't encourage institutional care. I'm

BEST COPY AVAILABLE

convinced we have to have institutions. We have to have hospitals; we have to have nursing homes; we have to have other facilities. But I'm also convinced that we are pushing a lot of people into making that choice when that choice isn't really medically necessary. So I think we have to help make more sense out of our laws and make them more sensitive in that way.

There are others who wanted to be here and have testimony or statements included in the record of the hearing. I have one which is a very interesting statement from Margaret Miller from North Benton County, where they have just received funding approval for a rural health care clinic, primary care clinic. It is very interesting and explains some of the difficulties that can be confronted by those who want to get together an application and present it for approval. Basically, they started trying to secure funding for a clinic in 1979 and it has just been approved in April of this year. This indicates some of the difficulties that can be confronted.

Also, Senator Stennis asked me to express his regret that he could not personally be here today.

Senator WEICKER. I bet very few of you know that Senator Stennis and I are graduates of the university—I hate to tell you this about your hometown Senator—University of Virginia Law School. That's where Senator Stennis and I both graduated. I bet you thought he went to the University of Mississippi. Not so. And John and I have gone up there on Law Day many times together. He is one fine man. He's got to be one of the greatest people I have ever known in my life.

Senator COCHRAN. Let me express again my appreciation for your being here, and for all of the witnesses who testified today. I think we have a good record of our hearing and it will really be of great benefit to us as we consider the problems that we have here in Mississippi, we look at the appropriate levels of funding for these programs, and particularly with the legislation that we have to vote on reauthorizing the programs under which many of our centers operate and our agencies operate.

And, again, let me express my deep appreciation to Senator Weicker for being here, without whose approval and support this hearing couldn't have been possible.

[Audience applauds.]

Senator COCHRAN. If things start getting bad up there, you can come down here and we can elect you sheriff or something; I don't know what. Maybe Senator.

BEST COPY AVAILABLE

CONCLUSION OF HEARING

Thank you all for being here. And thank you, Mr. Chairman.

That will conclude the hearing and we will stand in recess.

[Whereupon, at 1:10 p.m., Monday, May 21, the hearing was concluded and the subcommittee was recessed, to reconvene at the call of the Chair.]

○

BEST COPY AVAILABLE